

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10259

Reg. Dist. No.

10299

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN 1b D.O.A			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN						e. STREET ADDRESS 4803 WELLINGTON DR.			
3. NAME OF DECEASED (Type or print) First Middle Last FRANK RAPHAEL ACOSTA			4. DATE OF DEATH Month Day Year SEPT. 23 19 58			<input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/23		9. AGE (In years last birthday) 34 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 8 25			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer			12. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		13. BIRTHPLACE (State or foreign country) Canal Zone		14. CITIZEN OF WHAT COUNTRY? USA		
15. FATHER'S NAME Frank R. Acosta			16. MOTHER'S MAIDEN NAME Alice V. Acosta						
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or date of service) Yes Navy WW 2			18. SOCIAL SECURITY NO. None		19. INFORMANT Alice V. Acosta-mother-same as 2d				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 (c)								INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspiration of gastric contents								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Frank J. Broschart</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED			
EXAMINER'S NAME (Type) Frank J. Broschart			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9/26/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 25 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE
MONTH DAY

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-1

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Usual residence
7. Cause of death
8. Manner of death
9. Signature of medical examiner
10. Signature of coroner
11. Signature of registrar

12. Signature of physician
13. Signature of nurse
14. Signature of funeral director
15. Signature of undertaker
16. Signature of cemetery
17. Signature of burial place
18. Signature of interment
19. Signature of burial place
20. Signature of interment

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10300

CERTIFICATE OF DEATH

Reg. Dist. No.

10260

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admision) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 11½ yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,405 LORAIN AVENUE				d. STREET ADDRESS 10,405 LORAIN AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GEORGE Middle JOHN Last ADAMSON				4. DATE OF DEATH Month SEPT. Day 22 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/31/21	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Contractor				10b. KIND OF BUSINESS OR INDUSTRY (self-employed)		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME EDWARD E. ADAMSON				14. MOTHER'S MAIDEN NAME MINNIE KRUTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW # 2				16. SOCIAL SECURITY NO. 578-18-1916		17. INFORMANT Mrs. Elizabeth R. Adamson, 10,405 Lorain Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180x Hypernephroma, right kidney DUE TO with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 4 mos			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jun , 19 58 , to Sept , 19 58 , that I last saw the deceased alive on Sept 21 , 19 58 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard A. Fitzgerald				ADDRESS (Street, city or town, state) 217 University Blvd E. SS			
DATE SIGNED 9-22-58							
PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/25/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Juska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR SEP 24 58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Knapp			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAN 20 1925		BALTIMORE, MD.	
FATHER		MOTHER		SPOUSE		CHILDREN		BROTHERS		SISTERS	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JOHN H. HARRIS		WILLIAM H. HARRIS		ELIZABETH H. HARRIS	
EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS BIRTHS	
HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE		NONE	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
JAN 20 1925		J. H. HARRIS		JAMES H. HARRIS		JANE H. HARRIS		J. H. HARRIS		J. H. HARRIS	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

-10301

CERTIFICATE OF DEATH

Reg. Dist. No.

10261

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		1. d. STREET ADDRESS 5600 Muncaster Mill Road	
3. NAME OF DECEASED (Type or print) First Herbert Middle Nolan Last Adamson		4. DATE OF DEATH Month September Day 10 Year 1958 August 25 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert L. Adamson		14. MOTHER'S MAIDEN NAME Helen Adamson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		17. INFORMANT Robert L. Adamson, Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO Advanced Sen. Arteriosclerosis (c) Advanced Sen. Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Sept., 1958 , to 10 Sept., 1958 that I last saw the deceased alive on 9 Sept., 1958 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Zeigler		ADDRESS (Street, city or town, state) OLNEY, MD.	
PHYSICIAN'S NAME (Type) John B. Zeigler		DATE SIGNED 10 Sept 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-58	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		24a. REGISTERED BY REGISTRAR SEP 19 58	
24b. REGISTRAR'S SIGNATURE Arthur S. Flans		DATE	

CERTIFICATE OF DEATH

1901

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1901		Boston, Mass.	
Cause of Death		Disease		Duration		Time of Day		Month	
Heart Disease		Myocarditis		3 weeks		10:30 AM		January	
Occupation		Profession		Education		Marital Status		Previous Illness	
Carpenter		None		High School		Married		None	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G234 9/24/58 gsj

10262

10302

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Weaubleau</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>(no street address)</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>D. (initial only)</u> Last <u>Allen</u>				4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 25, 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William Allen</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Swicegood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unascertainable</u>			
17. INFORMANT Address <u>The Medical Record</u>				<u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Brain Tumor (confirmed by biopsy)</u> <u>17 yrs.</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable primary neoplasm of lung or kidney (unconfirmed) ?</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>1958</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 16,</u> <u>1958,</u> to <u>September 16, 1958,</u> that I last saw the deceased alive on <u>September 16, 1958,</u> and that death occurred at <u>5:10 A.M.,</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Lewis</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>9/16/58</u>			
PHYSICIAN'S NAME (Type) <u>William R. Lewis, M.D.</u>				DATE SIGNED <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Robbinson Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Weaubleau MO.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> <u>4812 GA Avenue</u>				24a. REC'D BY REGISTRAR <u>SEP 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10303

CERTIFICATE OF DEATH

Reg. Dist. No.

10263

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ralph Middle David Last Anderson				4. DATE OF DEATH Month September Day 10 , Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 11, 1917	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 10 Days 29		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fabrication Inspector				10b. KIND OF BUSINESS OR INDUSTRY Fabricating		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Grover Anderson				14. MOTHER'S MAIDEN NAME Lizzie Connine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 260-16-8045		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 286.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nontropical Sprue DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 13 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia, 24 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 31, 1958 to September 10, 1958 that I last saw the deceased alive on September 10, 1958 , and that death occurred at 11:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. G. O. Barnett M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/10/58			
PHYSICIAN'S NAME (Type) DR. G. O. BARNETT, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 9/11/58		22c. NAME OF CEMETERY OR CREMATORY Jeffersonville Cem.		22d. LOCATION (City, town, or county) (State) Jeffersonville, Ga.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR SEP 15 '58 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

12. Registrar's name: _____

13. Registrar's address: _____

14. Registrar's telephone: _____

15. Registrar's office: _____

16. Registrar's district: _____

17. Registrar's county: _____

18. Registrar's state: _____

19. Registrar's country: _____

20. Registrar's continent: _____

21. Registrar's world: _____

22. Registrar's universe: _____

23. Registrar's everything: _____

24. Registrar's nothing: _____

25. Registrar's somewhere: _____

26. Registrar's nowhere: _____

27. Registrar's everywhere: _____

28. Registrar's anywhere: _____

29. Registrar's everywhere: _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

10304

CERTIFICATE OF DEATH

10264

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>403 Joseph Street</u>				d. STREET ADDRESS <u>403 Joseph Street</u>			
3. NAME OF DECEASED (Type or print) First <u>THEODORE</u> Middle <u>WILLIAM</u> Last <u>ARMIGER</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25 1907</u>	9. AGE (In years last birthday) <u>50</u> yrs	IF UNDER 1 YEAR Months <u>11</u> Days <u>21</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bulldozer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Operator</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-16-2398</u>		17. INFORMANT <u>Alice V. Armiger-wife-same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLISM</u> DUE TO, (b) <u>ATELECTASIC - LEFT CHEST</u> DUE TO, (c) <u>BRACHIOGENIC CARCINOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> <u>2 MONTHS</u> <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>JULY 29, 1958</u> , to <u>SEPT 16, 1958</u> , that I last saw the deceased alive on <u>14 Sept.</u> , 1958, and that death occurred at <u>830 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u> M.D.				ADDRESS (Street, city or town, state) <u>26 W SUMMIT AVE</u>		DATE SIGNED <u>16 Sept 1958</u>	
PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>				<u>GATHERSBURG, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumprey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			



MEDICAL CERTIFICATION

V5 A1S (4)
ISM 9/55



10306

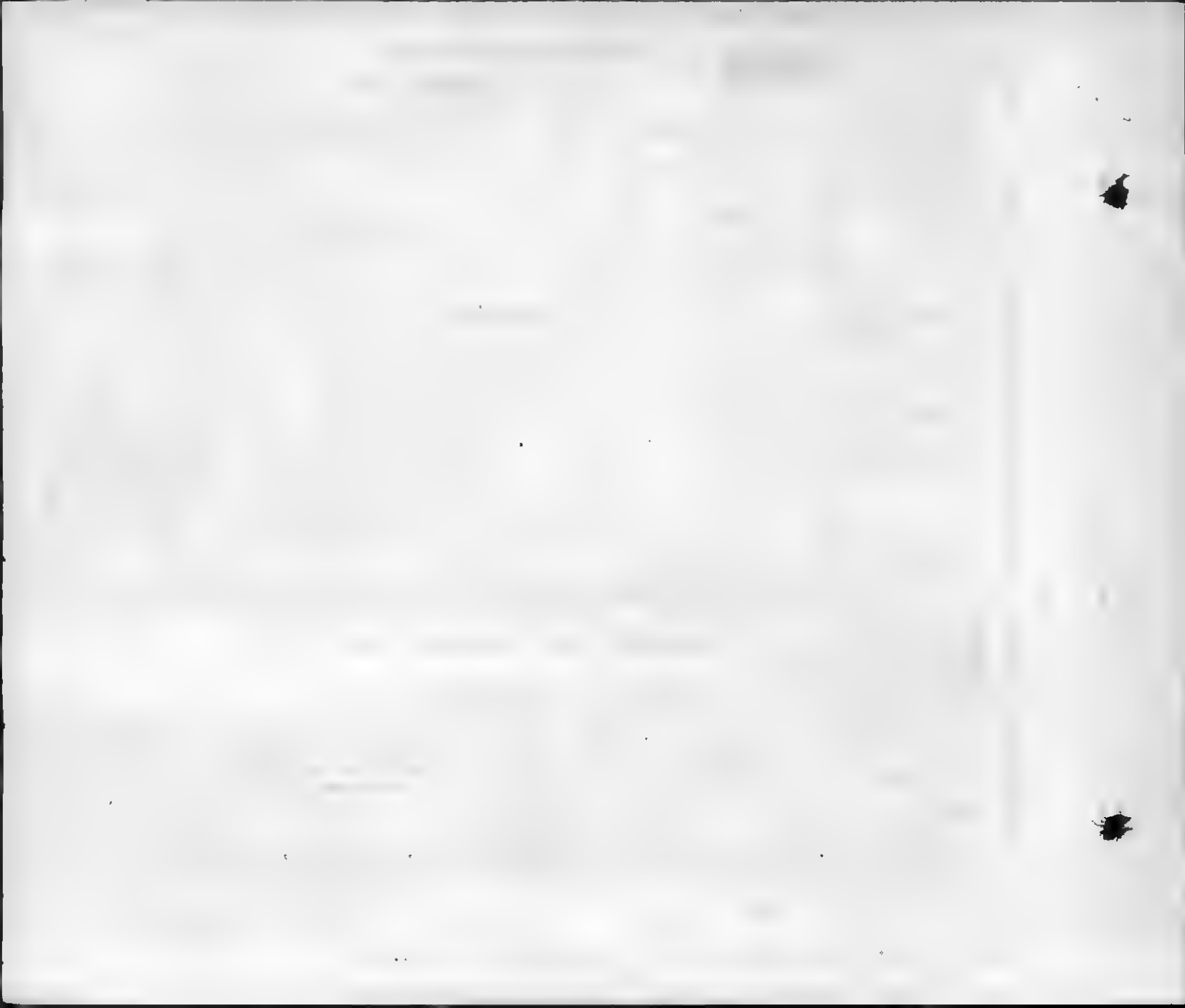
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4881 Battery Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE CLIFFORD ATWELL				4. DATE OF DEATH Month Day Year September 28, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2 1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 1 26	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Manager		10b. KIND OF BUSINESS OR INDUSTRY Ohio Audit Bureau Ohio		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 275-01-0189		17. INFORMANT Address Mrs. Harriet Blackstone-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arterio sclerosis DUE TO (c) years. INTERVAL BETWEEN ONSET AND DEATH Immediate							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/20 , 19 56 , to 9/28 , 19 58 , that I last saw the deceased alive on 8/22 , 19 58 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Paul D. Cantor M.D. 9/29/58							
ACTUAL SIGNATURE Paul D. Cantor							
PHYSICIAN'S NAME (Type) Paul D. Cantor - 4709 Montgomery Lane, Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-transit		10/1/58		Zanesville, Ohio			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Humphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

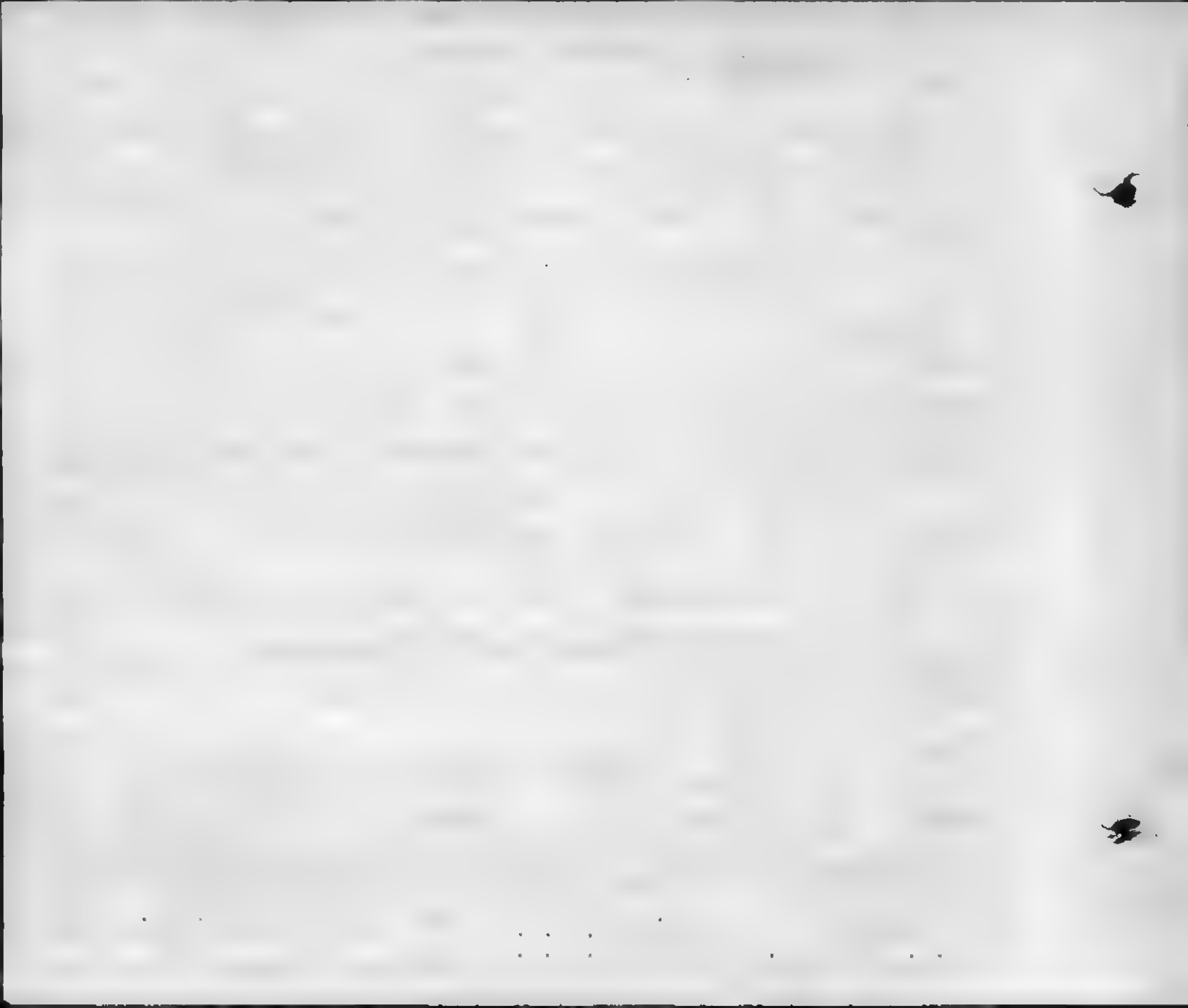
CERTIFICATE OF DEATH

Reg. Dist. No.

10267

10307

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>608 Dale Drive</u>				d. STREET ADDRESS <u>608 Dale Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Valorous Gage Austin</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1903</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Private Detective</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Credit Investigator</u>		11. BIRTHPLACE (State or foreign country) <u>Washington</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Valorous G. Austin</u>				14. MOTHER'S MAIDEN NAME <u>Blanche I. Boss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>320-34-9016</u>		17. INFORMANT <u>Mae C. Austin</u> wife Address <u>608 Dale Dr. SS. Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446x</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days 1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>advanced cerebral arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 15</u> , 1957, to <u>Sept 5</u> , 1958, that I last saw the deceased alive on <u>Sept 4</u> , 1958, and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>DB Washington</u> M.D. <u>6234 Fa Ave NW Wash DC</u>				DATE SIGNED <u>9/5/58</u>			
PHYSICIAN'S NAME (Type) <u>Daniel B. Washington M.D. 6234 Fa Ave NW Wash DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>SEP 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kious</u>	



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10308

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10268
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>4525 Windsor Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Joseph</u> Last <u>Ayers</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>19 58</u>			
5. SEX <u>M le</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/6/82</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>20</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Yard</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Ayers</u>				14. MOTHER'S MAIDEN NAME <u>Mary S. Ayers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Charles J. Ayers Jr.</u>		Address <u>8015 Glenbrook Rd. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis & myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>	
				20f. (City or town) <u>Bethesda</u>		(County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>8 AM - 9:26, 1958, to 12:45 PM</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-26</u> , 19 <u>58</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip P. James</u>				ADDRESS (Street, city or town, state) <u>M.D. Washington Clinic, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Philip P. James</u>				DATE SIGNED <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10309

Items 8 & 9, Film G-234 10/7/58 cag

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs</u>		d. STREET ADDRESS <u>Colisville-Beltsville Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colisville-Beltsville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Leonard G. Bailey</u>		4. DATE OF DEATH <u>9-13</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1922</u> 9. AGE (in years last birthday) <u>36 1/2</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov.</u>	
11. BIRTH-PLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Frances Rice</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>John T. Lancaster</u> Address <u>Ston 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO (b) <u>Epileptic Seizures</u> DUE TO (c) <u>6 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Final stand in bed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9-13-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEERT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-17-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworden</u>		24a. REC'D BY REGISTRAR <u>SEP 17 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10270.

10310

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. STREET ADDRESS 6312 93rd Ave.,			
3. NAME OF DECEASED (Type or print) First Curtis Middle Warren Last BARNARD				4. DATE OF DEATH Month September Day 19 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 July 1934		9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Donald W. BARNARD				14. MOTHER'S MAIDEN NAME Alyce Ruby BABB			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 9-3-52 to 8-23-56		16. SOCIAL SECURITY NO. to 8-23-56		17. INFORMANT (Wife) Mrs. Nancy L. BARNARD (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: 201X IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Sept. , 19 58 , to 19 Sept. , 19 58 , that I lost saw the deceased alive on 19 Sept. , 19 58 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE August Miale Jr.		M.D. U.S. Naval Hospital, Bethesda, Md.		ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) AUGUST MIALE, JR. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTIONS SIGNATURE W.W. Chambers, 5801 Cleveland Ave., Riverdale, Md.				24a. REC'D BY REGISTRAR SEP 23 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10271

10311

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>1915 Locust Grove Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1915 Locust Grove Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Augustine Barr</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm Barr</u>				14. MOTHER'S MAIDEN NAME <u>Julia Lynch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				17. INFORMANT <u>Ella Barr (wife)</u>			
16. SOCIAL SECURITY NO <u>Itm 2</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9-6-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>				ADDRESS <u>4812 GA Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>C. S. Lewis</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10270

CERTIFICATE OF DEATH

10272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN TB 22 hours		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. + Hosp.				d. STREET ADDRESS 6800 Red Top Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Philip		First Philip		Middle Martin		Last Bashwiner		4. DATE OF DEATH Month SEPT. Day 15 Year 1958	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/10/52		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired pressman		10b. KIND OF BUSINESS OR INDUSTRY Pressman		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME Martin Bashwiner				14. MOTHER'S MAIDEN NAME Isabel Carpenter					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT pt. hosp. chart + wife Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MELANOCARCINOMA, PRIMARY - COLON DUO TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) WITH METASTASIS TO LUNGS, BLADDER, LIVER DUO TO (c) AND LEFT PYLORETIC AND PYONEPHROSIS								INTERVAL BETWEEN ONSET AND DEATH MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rockville, Maryland		20g. (County) Montgomery	
21. I certify that I attended the deceased from June , 1957, to Sept , 1958, that I last saw the deceased alive on Sept 15 , 1958, and that death occurred at 3:30 P. M., from the causes and on the date stated above.									
ACTUAL SIGNATURE Ernest A. Sarooms		M.D. 7006 New Hampshire Ave. Tk. Pk. Md.		DATE SIGNED 9/15/58					
PHYSICIAN'S NAME (Type) Ernest A. Sarooms		7006 New Hampshire Ave. Tk. Pk. Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/58		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Rumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10312

Reg. Dist. No

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived (If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>45 yrs</u>		d. STREET ADDRESS <u>813 Univ. Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>813 Univ. Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Amy Lavinia Beall</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-8-95</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gen. W. Mullikin</u>		14. MOTHER'S MAIDEN NAME <u>Leona New Van Horn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>30 ym</u>	
17. INFORMANT <u>Wilma Lewis</u>		Address <u>Stun</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetic Mellitus</u> (a), stating the underlying cause last. DUE TO (c) <u>30 ym</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 10 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		ADDRESS <u>4812 GA Ave NW</u>	
24a. REC'D BY REGISTRAR <u>SEP 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thase</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



10313

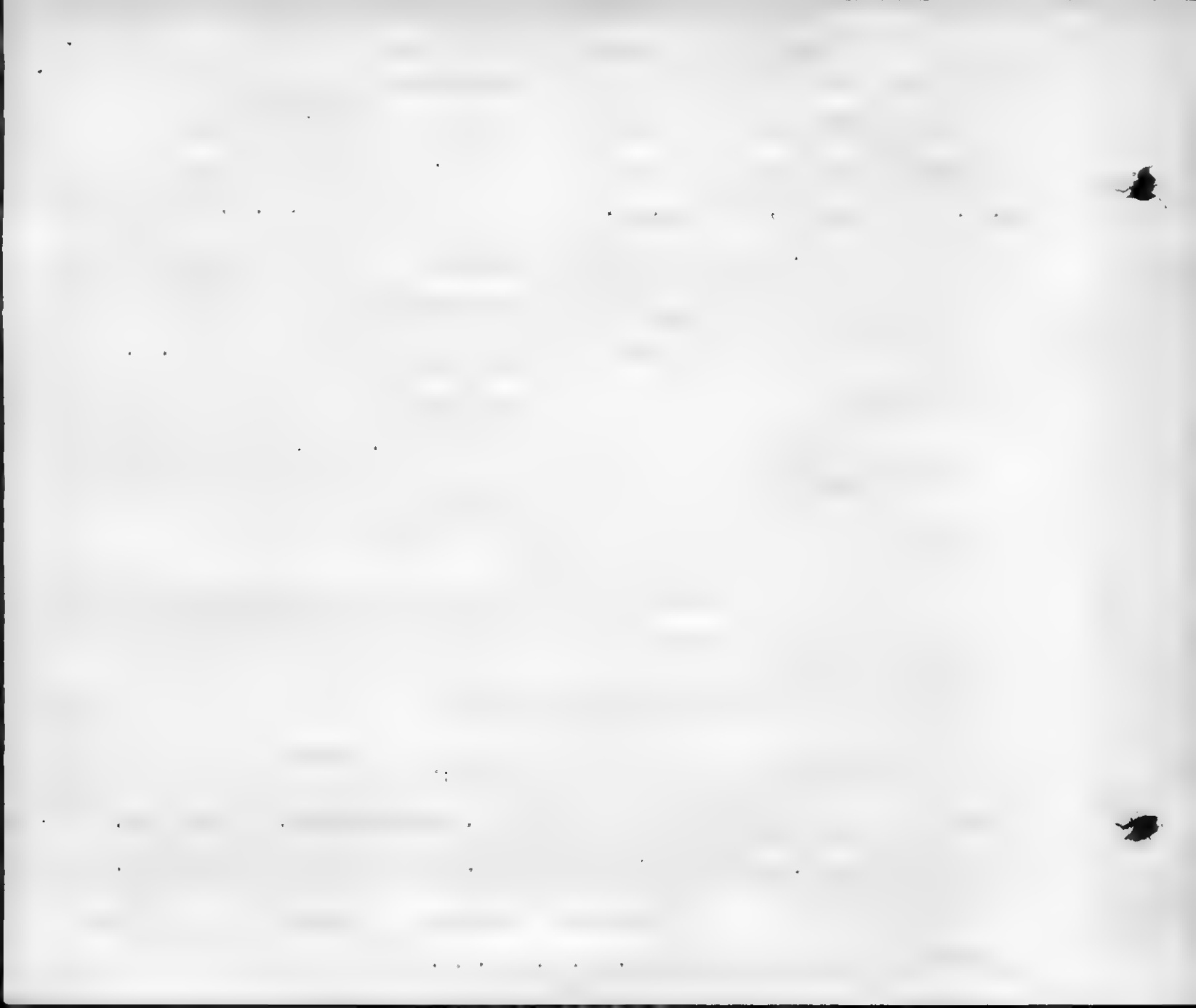
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN b 4 days				d. STREET ADDRESS 529 Eames Place, N. E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lillie Mae Roebuck BELCHER				4. DATE OF DEATH Month Day Year September 19 1958			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 September 1922	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Elizah ROUNTREE				14. MOTHER'S MAIDEN NAME Lula HENDERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Joe N. BELCHER (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 September, 1958 , to 19 September 1958 , that I last saw the deceased alive on 19 September , 19 58 , and that death occurred at 7:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, Bethesda, Md. 9-20-58							
ACTUAL SIGNATURE Douglas R. Koth		M.D. U. S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) Douglas R. KOTH		LT MC USN U. S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE SPANGLER, Funeral Home, 524, 8th St., N. E. Wash. D. C.				24a. REC'D BY REGISTRAR SEP 23 58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10314

CERTIFICATE OF DEATH

10275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS Seven Locks Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle Blockson Last Blockson				4. DATE OF DEATH Month September Day 4 Year 1958			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 10, 1901	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Geneviva Mason			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Jenny Wells (friend)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia						1 week	
DUE TO 446x							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) Arteriosclerosis	
						unknown	
DUE TO Generalized arteriosclerosis						unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1, 1958 , to Sept. 3, 1958 , that I last saw the deceased alive on Sept. 3, 1958 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Bowditch Huntzfer M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL-CREMATORY RECORD (See instructions)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Sept 10 1958		Soldiers Home		Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden - Rockville				24. REC'D BY REGISTRAR SEP 11 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10276

10315

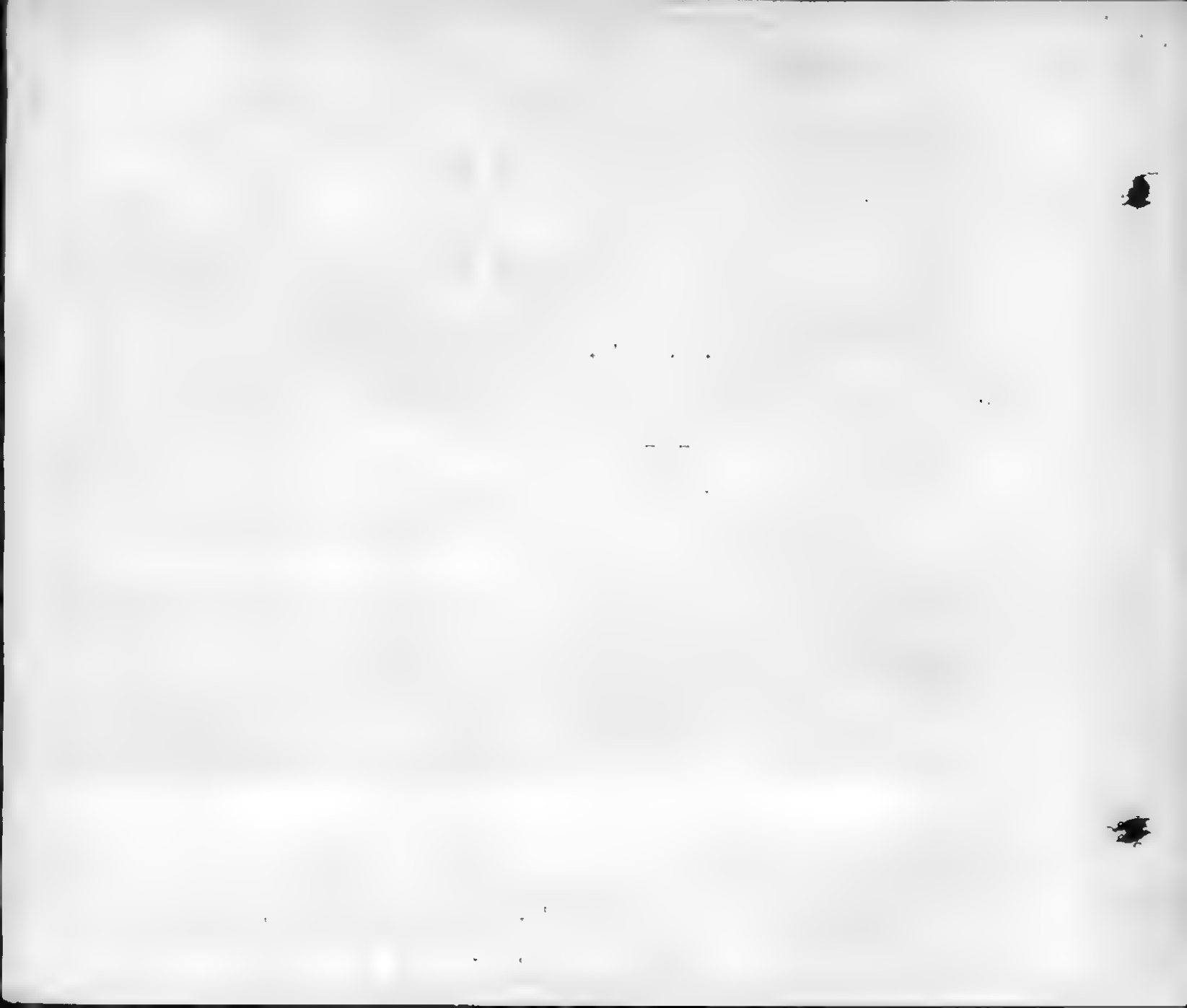
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>1 min.</u>				d. STREET ADDRESS <u>12623 Epping Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12621 Epping Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Joseph Boland</u>				4. DATE OF DEATH <u>Sept 29 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-28-07</u>	
9. AGE <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Marshall</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>			
11. BIRTHPLACE (State or foreign country) <u>Mass</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>			
13. FATHER'S NAME <u>Wm Henry Boland</u>				14. MOTHER'S MAIDEN NAME <u>Mary Driscoll</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>WW # 2 579-22-3084</u>			
17. INFORMANT <u>Gladys Boland (wife)</u>				Address <u>Stem 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>10/2/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Gurka</u>				ADDRESS <u>SILVER SPRING, MD.</u>			
24a. REC'D BY REGISTRAR <u>OCT 1 58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10316

Item 9
CERTIFICATE OF DEATH

Reg. Dist. No.

10277

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MD.</u> <u>MARYLAND</u>				7. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDEN NURSING HOME</u>				d. STREET ADDRESS <u>2406 19th St NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WUWIA</u>		First <u>WUWIA</u> Middle <u>G</u> Last <u>BOOKWALTER</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 24 1883</u>	
9. AGE (in years last birthday) <u>74</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MISSIONARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHOF SOUTH INDIA</u>		11. BIRTHPLACE (State or foreign country) <u>KNOXVILLE TENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>NEWIS BOOKWALTER</u>		14. MOTHER'S MAIDEN NAME <u>EMMA GUITNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS RUTH HUMMEL</u>		Address <u>2406 19th St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 13</u> , 19 <u>57</u> , to <u>Sept. 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 4</u> , 19 <u>58</u> , and that death occurred at <u>7:17</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Katharine A. Chapman</u> M.D.				ADDRESS (Street, city or town, state) <u>3924 BARTO AVE KENSINGTON</u>			
PHYSICIAN'S NAME (Type) <u>KATHARINE A. CHAPMAN</u>				DATE SIGNED <u>Sept. 4 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>SEPT 6 1958</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Dean Hill cemetery</u>	
22d. LOCATION (City, town, or county) <u>Switzerland</u>				22e. (State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Binko & Sons</u>				ADDRESS <u>3034 11th St NW</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	
24a. REC'D BY REGISTRAR <u>SEP 9 '58</u>				DATE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10278

Reg. Dist. No.

10317

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9404 Kingsley Ave</u>		e. STREET ADDRESS <u>9404 Kingsley Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>MARIA</u> Middle <u>BORZI</u> Last <u>BORZI</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/8/1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>18</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
13. BIRTHPLACE (State or foreign country) <u>USA</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Paul R Borzi</u>		16. MOTHER'S MAIDEN NAME <u>Santa Calderaro</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>578-46-8824B</u>	
19. INFORMANT <u>Mary G Borzi Dtr Same # 2</u>		20. ADDRESS <u>Address</u>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
(b) <u>Chronic Cardio - renal disease</u>			<u>1 mo.</u>
(c) <u>Carcinoma of left breast with metasyasis</u>			<u>7 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
23a. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23d. (City or town) (County) (State)	
24. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/26/58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		25a. REC'D BY REGISTRAR	
25b. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		25c. REGISTRAR'S SIGNATURE <u>Robert A. Humphrey</u>	
25d. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		25e. DATE THEREOF <u>9/29/58</u>	
25f. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		25g. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
25h. ADDRESS <u>Bethesda, Maryland</u>		25i. DATED <u>SEP 30 1958</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 10318

CERTIFICATE OF DEATH

Reg. Dist. No.

10279

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						d. STREET ADDRESS Washington 27, D.C.						e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Jennie		Middle Elizabeth		Last Bowers		4. DATE OF DEATH		Month September		Day 17,		Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1921		9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR: Months 37		IF UNDER 24 HRS: Days 37		Hours 37			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Rhode Island				12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Anthony Hanczarek						14. MOTHER'S MAIDEN NAME Tekla Knopik											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. 035-18-284						17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intra cerebral hemorrhage (c) Acute Myelocytic Leukemia												INTERVAL BETWEEN ONSET AND DEATH 5 weeks					
												PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from September 11, 1958 , to September 17, 1958 , that I last saw the deceased alive on September 17, 1958 , and that death occurred at 6:40 P.M. , from the causes and on the date stated above.																	
ACTUAL SIGNATURE Arthur L. Teplitzky M.D.						ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland						DATE SIGNED 9/18/58					
PHYSICIAN'S NAME (Type) Arthur L. Teplitzky, M.D.																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-22-58		22c. NAME OF CEMETERY OR CREMATORY Huntington Nat'l.				22d. LOCATION (City, town, or county) (State) St. Myer, Va.							
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambliss, Jr.						ADDRESS 577 N. St. SE		24a. REC'D BY REGISTRAR SEP 22 58		24b. REGISTRAR'S SIGNATURE W.D. H. DE							

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10319

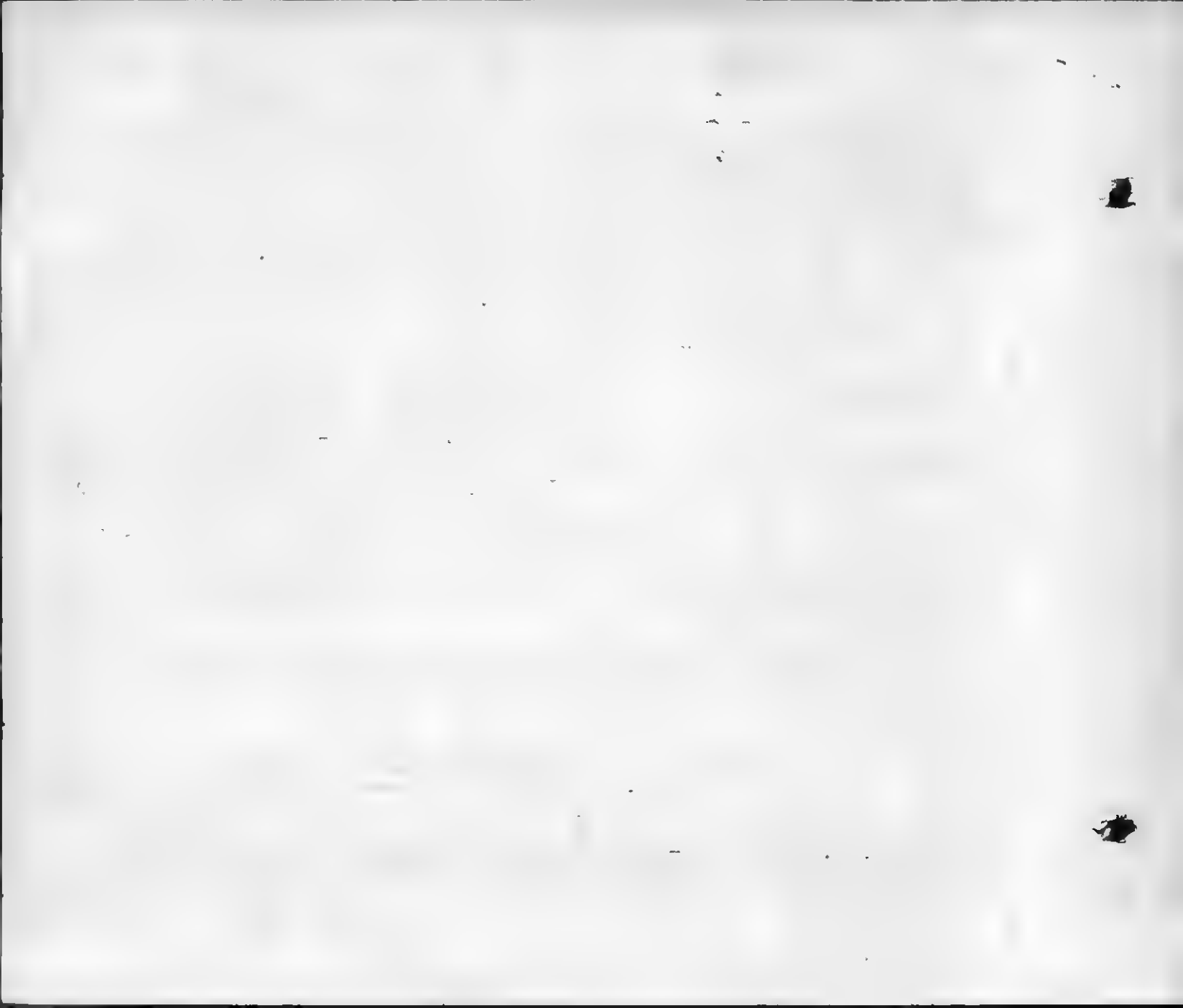
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Springfield			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5606 Parkston Road				d. STREET ADDRESS 5606 Parkston road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle JOSEPHINE Last BROADBENT				4. DATE OF DEATH Month Sept. Day 3 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 8 Days 8		IF UNDER 24 HRS. Hours 8 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME John Ryder				14. MOTHER'S MAIDEN NAME Margaret ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Leonard S. Broadbent-same as item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERAL DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH 7 MO. 4 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 9, 1956 to SEPT. 3, 1958 , that I last saw the deceased alive on SEPT. 2, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo M. Curtis				ADDRESS (Street, city or town, state) -8218 Wisconsin Avenue, Bethesda, Maryland			
DATE SIGNED 9-3-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/58		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 5 '58	
				24b. REGISTRAR'S SIGNATURE Charles S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

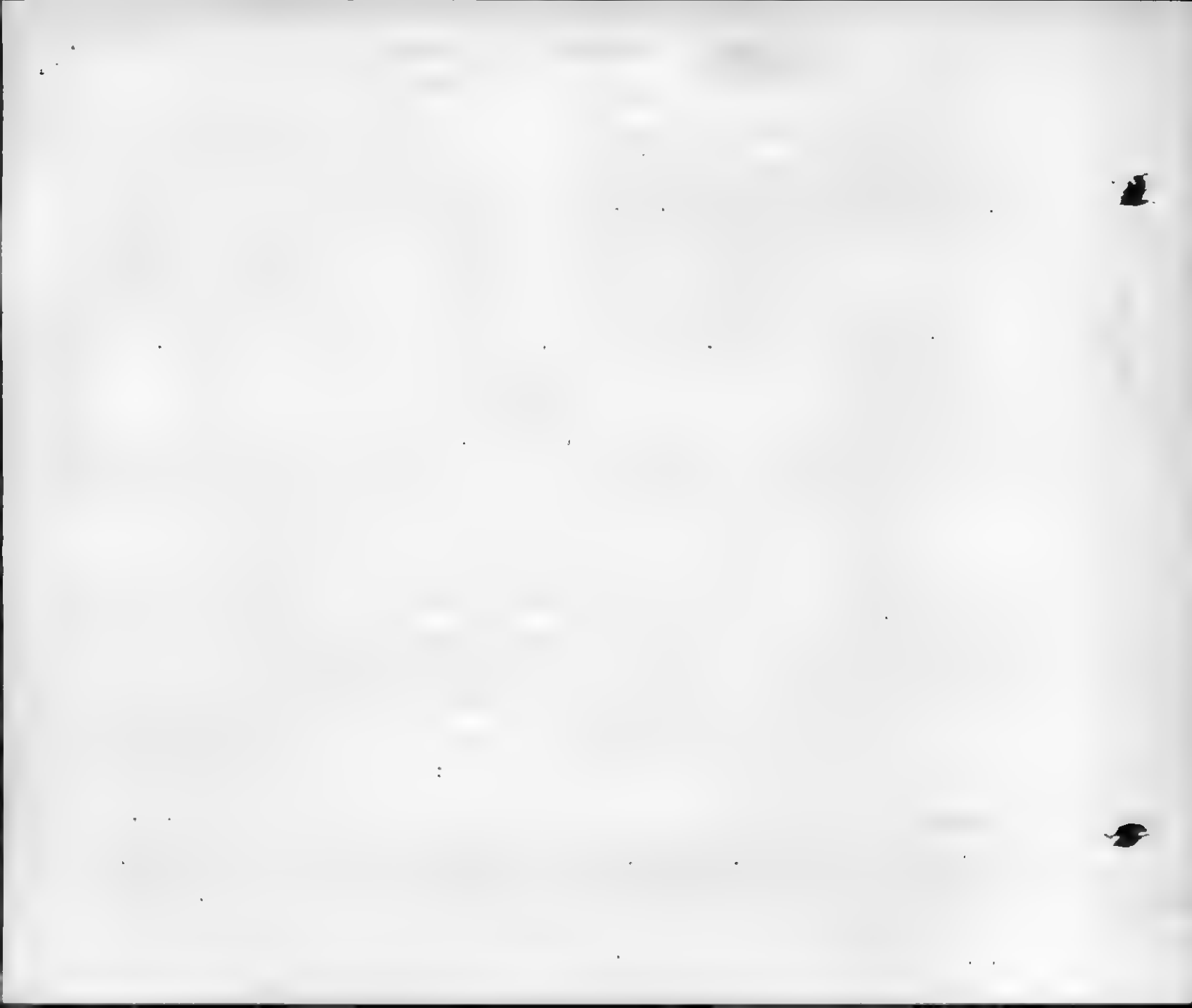
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10320

CERTIFICATE OF DEATH

Reg. Dist. No. 10281
215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE Maryland c. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 43 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 5112 Moreland Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Waite Orville Last BUNKER		4. DATE OF DEATH Month September Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 February 1882
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles BUNKER		14. MOTHER'S MAIDEN NAME Isola BEASSWELE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I & II		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT (Wife) Mrs. Eleanor G. BUNKER (Same As #2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3-4 hrs Many Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction (b) Curious of heart.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Curious of heart.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 August 19 58 to 17 September 19 58 , that I last saw the deceased alive on 17 September 19 58 , and that death occurred at 1:35 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. J. Pearson, Jr.		DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-17-58	
PHYSICIAN'S NAME (Type) R. J. Pearson, Jr. CAPT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 9-22-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md		24a. REC'D BY REGISTRAR SEP 22 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10321

Item 11: Film C233 9/19/58 pag

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

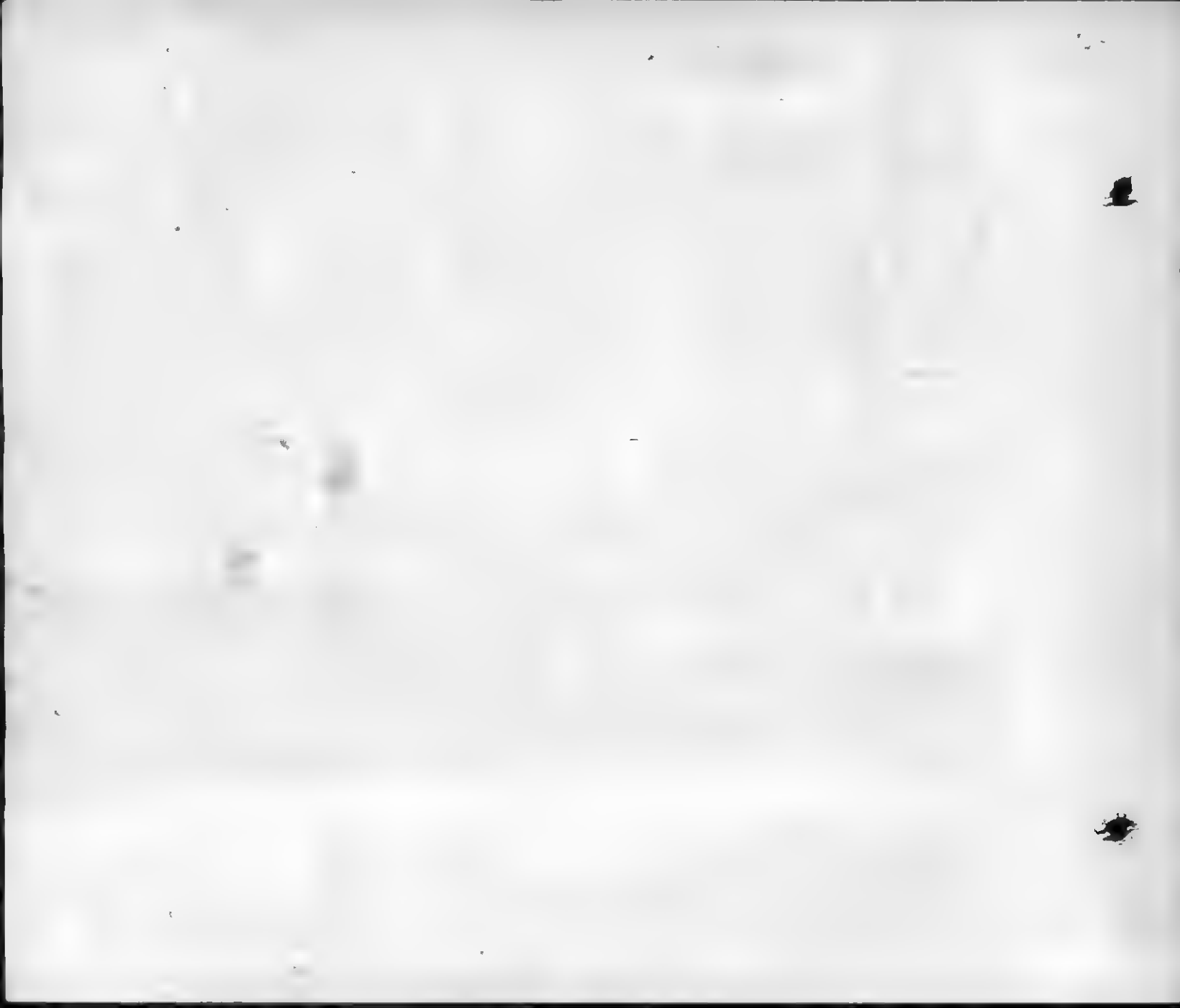
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>md</u> b COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate lim't, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate lim't, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3302 Weller Rd</u>		d. STREET ADDRESS <u>3302 Weller Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Edward Patrick Burke</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-96</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water front com.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y. state</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Patrick Burke</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>092/05-3171</u>	
17. INFORMANT <u>Edw. Burke (son)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bruschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PAPLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond G. Glick</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10322

CERTIFICATE OF DEATH

Reg. Dist. No.

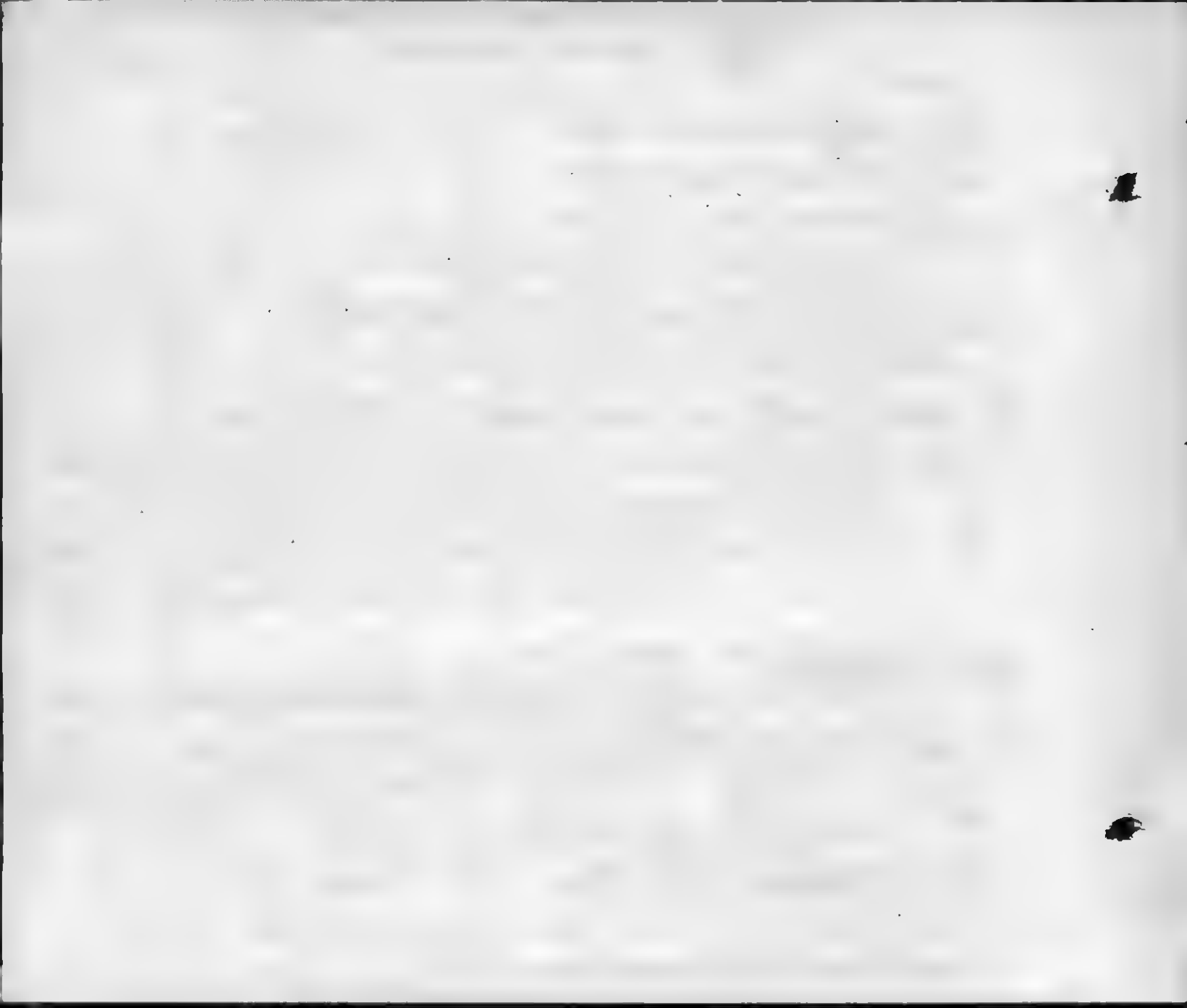
10283

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C. MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomena's Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First Middle Last				4. DATE OF DEATH <u>Sept 21</u> Month Day Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21-1870</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
13. FATHER'S NAME <u>Wm. Pender</u>				14. MOTHER'S MAIDEN NAME <u>Mary Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wm. J. Caesar</u> Address <u>1229-29th St. NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>20 years</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Sept. 1, 1958</u> , to <u>Sept. 21, 1958</u> , that I last saw the deceased alive on <u>Sept. 16, 1958</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry J. Kicherer</u>				ADDRESS (Street, city or town, state) <u>2205 Richland St. Silver Spring, Md.</u> DATE SIGNED <u>9-21-58</u>			
PHYSICIAN'S NAME (Type) <u>Harry J. Kicherer</u>				<u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 25, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) <u>WASHINGTON D.C.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Agnes Funeral Home</u> ADDRESS <u>2214 11th St</u>				24a. REC'D BY REGISTRAR <u>SEP 26 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10323

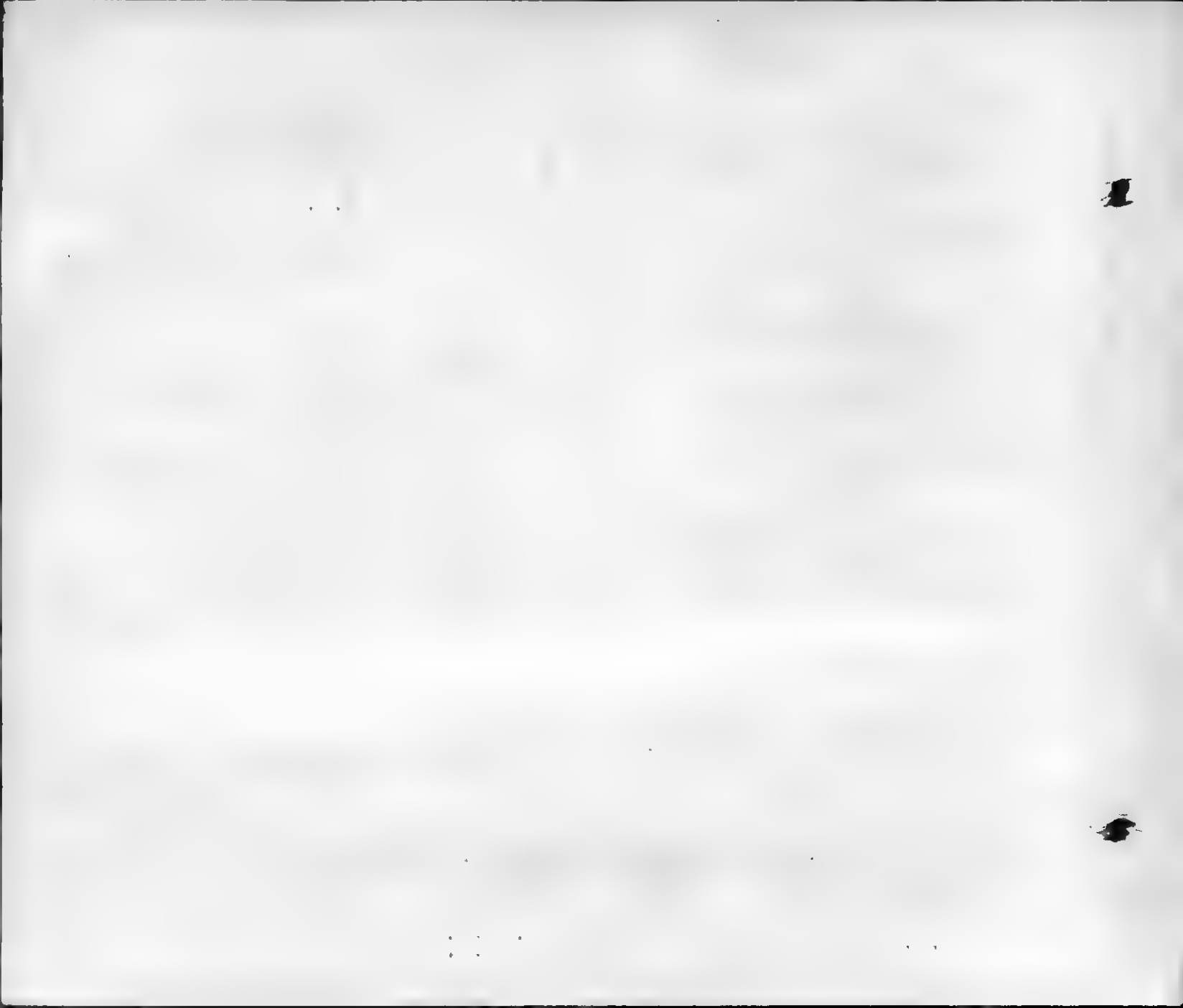
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN TB 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) SUBURBAN				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.			
f. STREET ADDRESS 2001 16th St. N.W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ESTELLE Middle B Last CAMPBELL				4. DATE OF DEATH Month SEPT. Day 21 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/3/78	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Min 21		11. IF UNDER 24 HRS Months 21 Days 21 Hours 21 Min 21		12. IF UNDER 24 HRS Months 21 Days 21 Hours 21 Min 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Buffalo, New York			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Ball				14. MOTHER'S MAIDEN NAME Mary Cohn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Son (Geo. Campbell)			
17. INFORMANT Son (Geo. Campbell)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, Posterior Septal + Posterior Left Ventricle 48							
DUE TO Coronary Thrombosis 48							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis Unknown							
DUE TO Coronary Arteriosclerosis Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1938 to Sept 21 19 58 , that I last saw the deceased alive on 21 Sept 19 58 , and that death occurred at 9:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John G. Ball M.D.							
PHYSICIAN'S NAME (Type) JOHN G. BALL 7936 Old Georgetown Rd. Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
removal		9/22/58		Oakland Cemetery		Warren, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company				24a. REC'D BY REGISTRAR SEP 23 '58			
24b. REGISTRAR'S SIGNATURE C. S. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



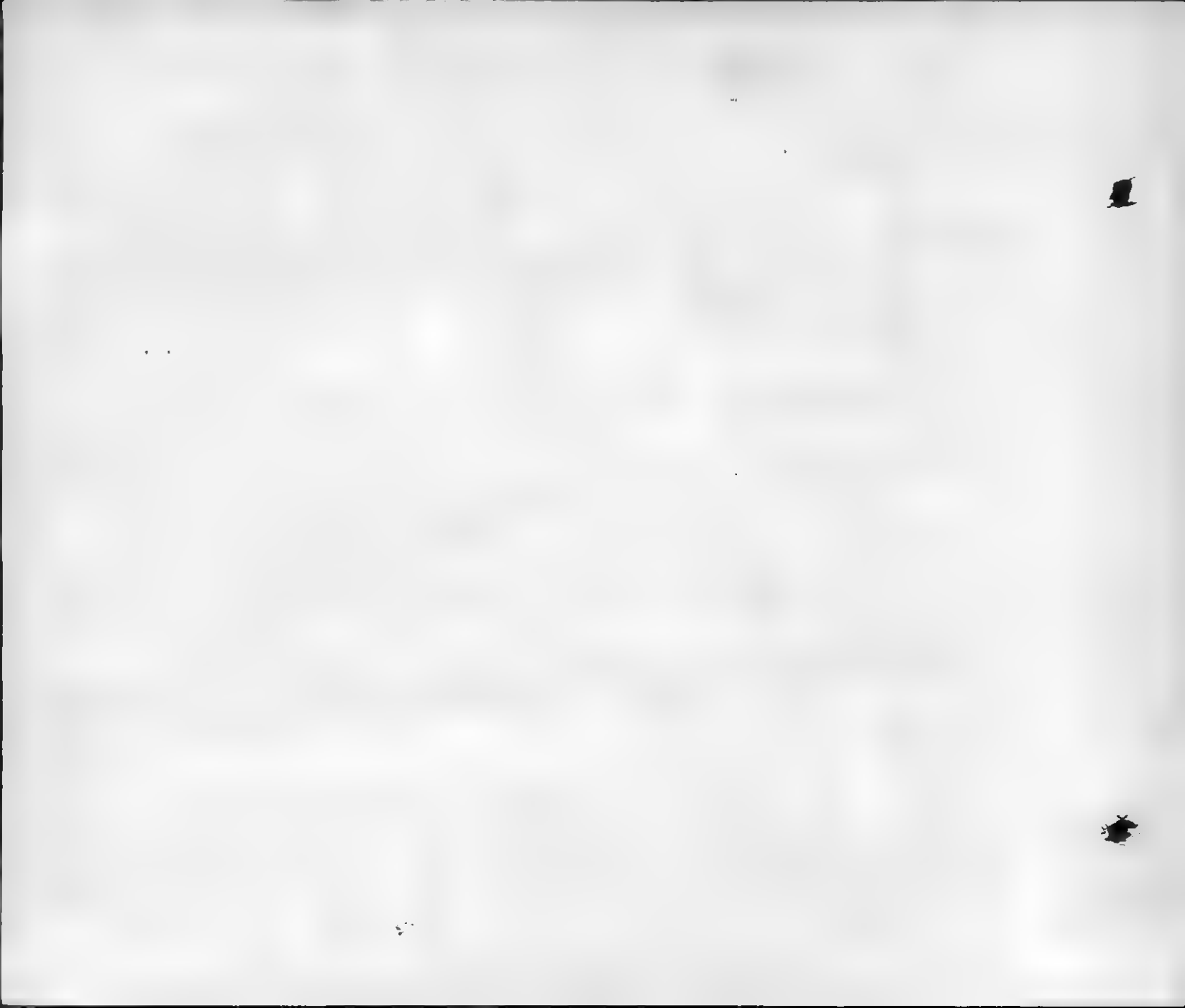
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 5908 Cedar Parkway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Arthur Middle Francis Last Carroll Jr.				4. DATE OF DEATH Month September Day 21 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 28, 1911	
9. AGE (In years last birthday) 47 46 yrs.		IF UNDER 1 YEAR Months 47 Days 46 Hours 46 Min.		IF UNDER 24 HRS. Months 47 Days 46 Hours 46 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer				10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Arthur Francis Carroll				14. MOTHER'S MAIDEN NAME Annie Ryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220		17. INFORMANT Mary H. Carroll - same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination DUE TO Ruptured Esophageal Varices Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cirrhosis of liver (b) Cirrhosis of liver (c) Cirrhosis of liver				INTERVAL BETWEEN ONSET AND DEATH Immediate Unknown			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) WASH., D.C.				20g. (County) DC			
20h. (State) DC							
21. I certify that I attended the deceased from 3-19 , 19 58 , to 9-21 , 19 58 , that I last saw the deceased alive on 9-20 , 19 58 , and that death occurred at 6:05 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Fleet Lickett				ADDRESS (Street, city or town, state) 5800 Penn Rd NW			
DATE SIGNED 9-21-58							
PHYSICIAN'S NAME (Type) W. FLEET LICKETT							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-24-1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Oliver		22d. LOCATION (City, town, or county) (State) WASH., D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan				ADDRESS 317 Penn Ave SE		24a. REC'D BY REGISTRAR DATE SEP 23 '58	
				24b. REGISTRAR'S SIGNATURE William L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10286

10325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 7 hrs. 5mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County Gen. Hospital		d. STREET ADDRESS Sandy Spring, Md.	
3. NAME OF DECEASED (Type or print) First Ella Middle Mae Last Carter		4. DATE OF DEATH Month 9- Day 28 Year 1958	
5. SEX Female	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Clifton Edward Thomas		14. MOTHER'S MAIDEN NAME Mary Simpson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Eugene Carter		Address Sandy Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma and 350X DUE TO Sub-Arachnoid hemorrhage- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sub-Arachnoid hemorrhage- DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Broncho-pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/28 , 19 58 , to 9/28 , 19 58 , that I last saw the deceased alive on 9/28/58 , 19 58 , and that death occurred at 1:35 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 9/30/58			
SIGNATURE A. D. Bonifant		M.D. Sandy Spring, Md.	
PHYSICIAN'S NAME (Type) A. D. BONIFANT		ADDRESS Sandy Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-2-58	22c. NAME OF CEMETERY OR CREMATORY Sandy Spring	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR Oct 6 58		24b. REGISTRAR'S SIGNATURE Charles E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 10287

10326

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d STREET ADDRESS <u>Glen Hills</u>	
3 NAME OF DECEASED (Type or print) <u>First Minnie Middle M Last Cavanaugh</u>		4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>19 58</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>September 12, 1892</u>
9 AGE (If years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS <u> </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>ALEXANDRA GOROUN</u>	
14. MOTHER'S MAIDEN NAME <u>Hattie ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO. <u>212-16-9319A</u>		17. INFORMANT <u>Mr. Bernard Cavanaugh-same as item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebrum</u> DUE TO (c) <u>Metastatic Ca from uterine</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 wk</u> <u>9 mos</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1, 1957</u> to <u>2/4/1958</u> , that I last saw the deceased alive on <u>2/4/1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M D		<u>Rockville, Md</u> <u>9/4/58</u>	
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		<u>Rockville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 9 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

10327

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10288
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 4323 Raleigh Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last CHOPLOSKY		4. DATE OF DEATH Month September Day 8 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 August 1958
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months 9 Days	IF UNDER 24 HRS Hours 9 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Joseph CHOPLOSKY		14. MOTHER'S MAIDEN NAME Mary Elizabeth BRUBAKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) John H. CHOPLOSKY (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Meningitis, acute. DUE TO 751X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meningococci, lumbo sacral DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 30 Aug 19 58 , to 8 Sept. 19 58 , that I last saw the deceased alive on 8 SEPT. 19 58 , and that death occurred at 6:05A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David Harris M.D.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
DATE SIGNED 9-8-58			
PHYSICIAN'S NAME (Type) David Harris, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-9-58	22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 3072 "M" St. N.W. Washington, D.C.		REC'D BY REGISTRAR SEP 10 '58	24b. REGISTRAR'S SIGNATURE Arthur E. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10328

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1725 Beall Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul Leo Christy</u>		4. DATE OF DEATH Month Day Year <u>Sept 9 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/38</u>
9. AGE (in years last birthday) yrs. <u>20</u>		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min. <u>1 22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bethesda, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leo E. Christy</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Mc Fadden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Chart of mother</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Atelectasis obstructive</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arachnoid hemorrhage, vertex</u> DUE TO <u>Birth trauma</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Two hrs</u> <u>1 + day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital heart lesion - Patent foramen ovale &</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>ductus arteriosus</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 8</u> , 19 <u>58</u> , to <u>Sept 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 9</u> , 19 <u>58</u> , and that death occurred at <u>11:55</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen C. Cromwell</u> M.D. <u>615 W. Montgomery Ave. Rockville, Md.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>9/12/58</u>	
PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell</u>		<u>615 W. Montgomery Ave. Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10329

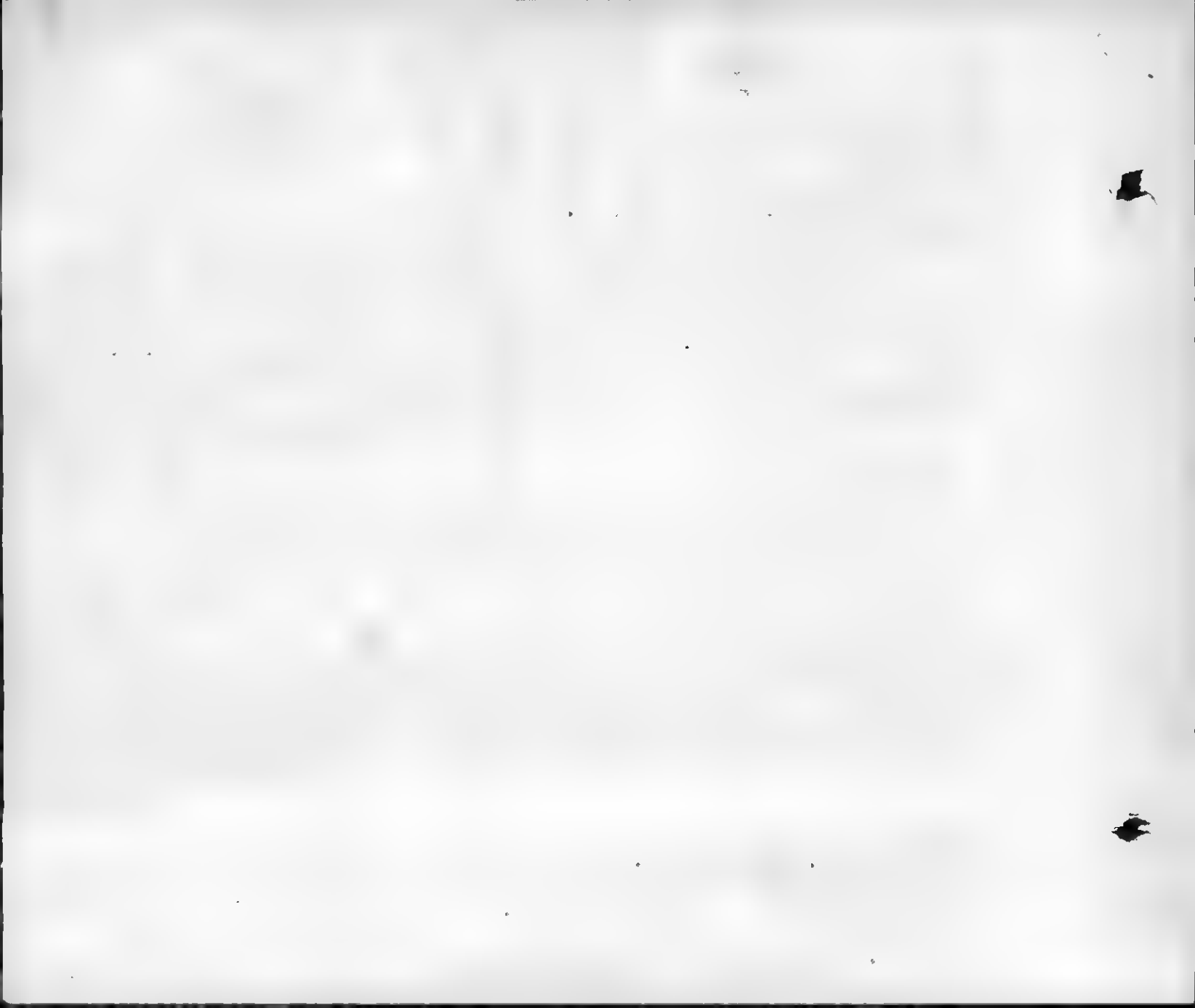
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Virginia b. COUNTY Dickenson			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stratton			
c. LENGTH OF STAY IN 1b 9 days				d. STREET ADDRESS No Street Address			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Polly Middle Mae Last Church				4. DATE OF DEATH Month September Day 12 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1925	
9. AGE (In years last birthday) 33 yrs		IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min 33		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Edward Newberry				14. MOTHER'S MAIDEN NAME Sarah Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial Hemorrhage, Post DUE TO Left atrial catheterization CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PERICARDIAL HEMORRHAGE, POST LEFT ATRIAL CATHETERIZATION INTERVAL BETWEEN ONSET AND DEATH 7 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic rheumatic valvulitis (CHRONIC RHEUMATIC VALVULITIS)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year September 3, 19 58				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 3, 19 58 , to September 12, 19 58 , that I last saw the deceased alive on September 12, 19 58 , and that death occurred at 6:58 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon I. Goldberg M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/13/58			
PHYSICIAN'S NAME (Type) LEON I. Goldberg, M.D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/58		22c. NAME OF CEMETERY OR CREMATORY Newberry Cem.		22d. LOCATION (City, town, or county) (State) Tarpon, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10330

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Mercer</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princeton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		d. STREET ADDRESS <u>118 Snowden Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>Ireland</u> Last <u>Clinton</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>20</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Clinton</u>		14. MOTHER'S MAIDEN NAME <u>Frances Ann Ireland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. John Dickinson</u>		Address <u>Bethesda, Md. 5521 Charles St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>471</u> <u>Broncho pneumonia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 30</u> , 19 <u>58</u> , to <u>Sept 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 21</u> , 19 <u>58</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10571 Summit Ave Kensington, Md.</u> DATE SIGNED <u>Sept 23 '58</u>			
ACTUAL SIGNATURE <u>George Sharpe</u>		M.D. <u>10571 Summit Ave Kensington, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Thompson</u>		ADDRESS <u>4557 Thosomom Rd</u>	
24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hirsch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the general director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

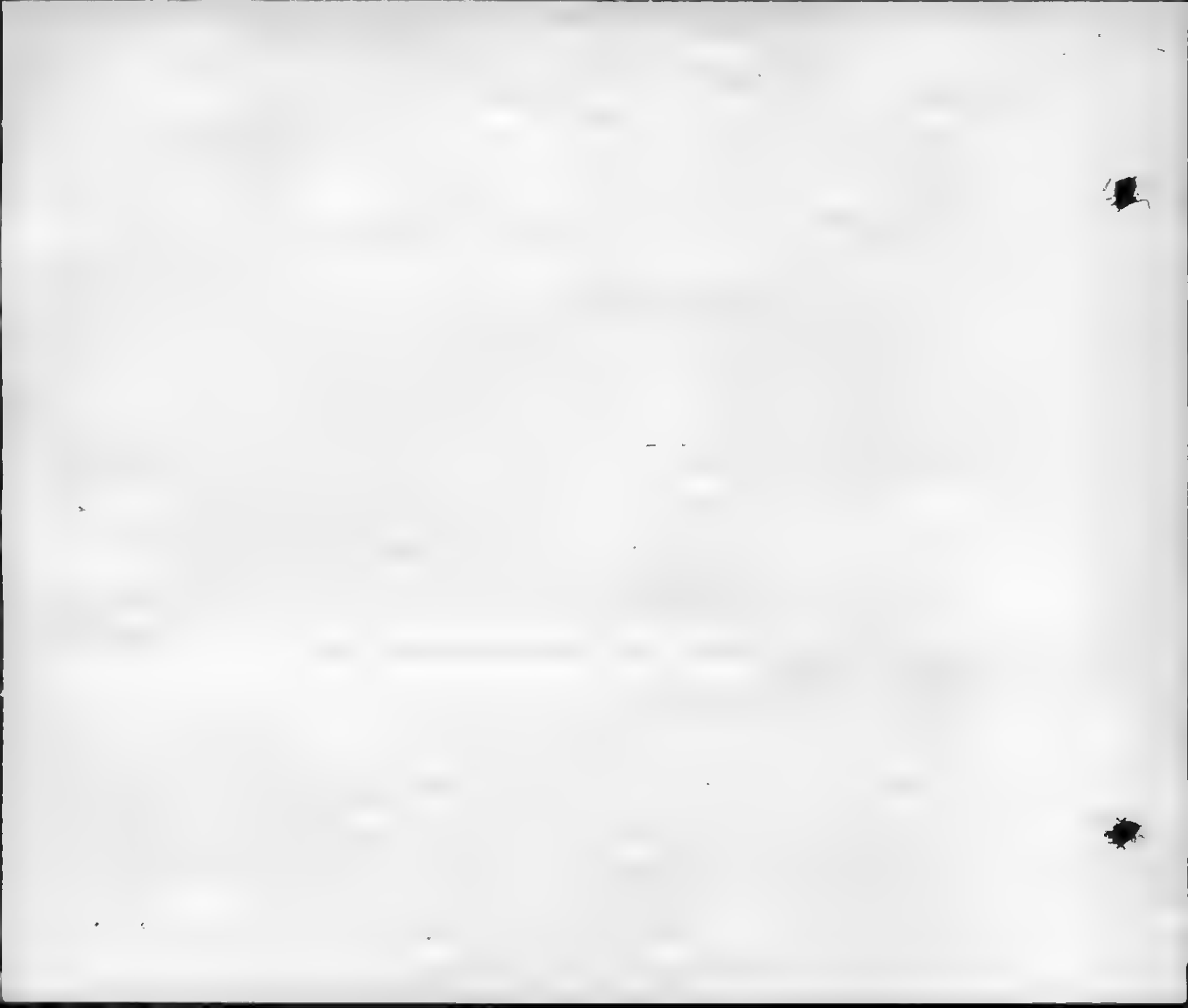
10292

10271

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tahoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>		d. STREET ADDRESS <u>9604 Evergreen St.</u>	
3 NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Milton</u> Last <u>Collins</u>		4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-85</u>
9. AGE (In years lost birthday) <u>72 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer + building Supt.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Collins - Mr. Albert B.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>719-18-7479</u>	
17. INFORMANT <u>Parent -</u>		Address <u>as above</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma left lung with</u> DUE TO <u>metastasis to liver, 2 Pericardial effusion,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>massive Pulmonary edema</u> DUE TO (c) <u>massive Pulmonary edema</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 13</u> , 19 <u>58</u> , to <u>Sept 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>58</u> , and that death occurred at <u>2:05 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u> DATE SIGNED <u>9-2-58</u>	
PHYSICIAN'S NAME (Type) <u>Philip E Jones</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMAT ON, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Humphrey</u>		ADDRESS <u>8434 Gt Ave</u>	
24a. REC'D BY REGISTRAR <u>SEP 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



CERTIFICATE OF DEATH

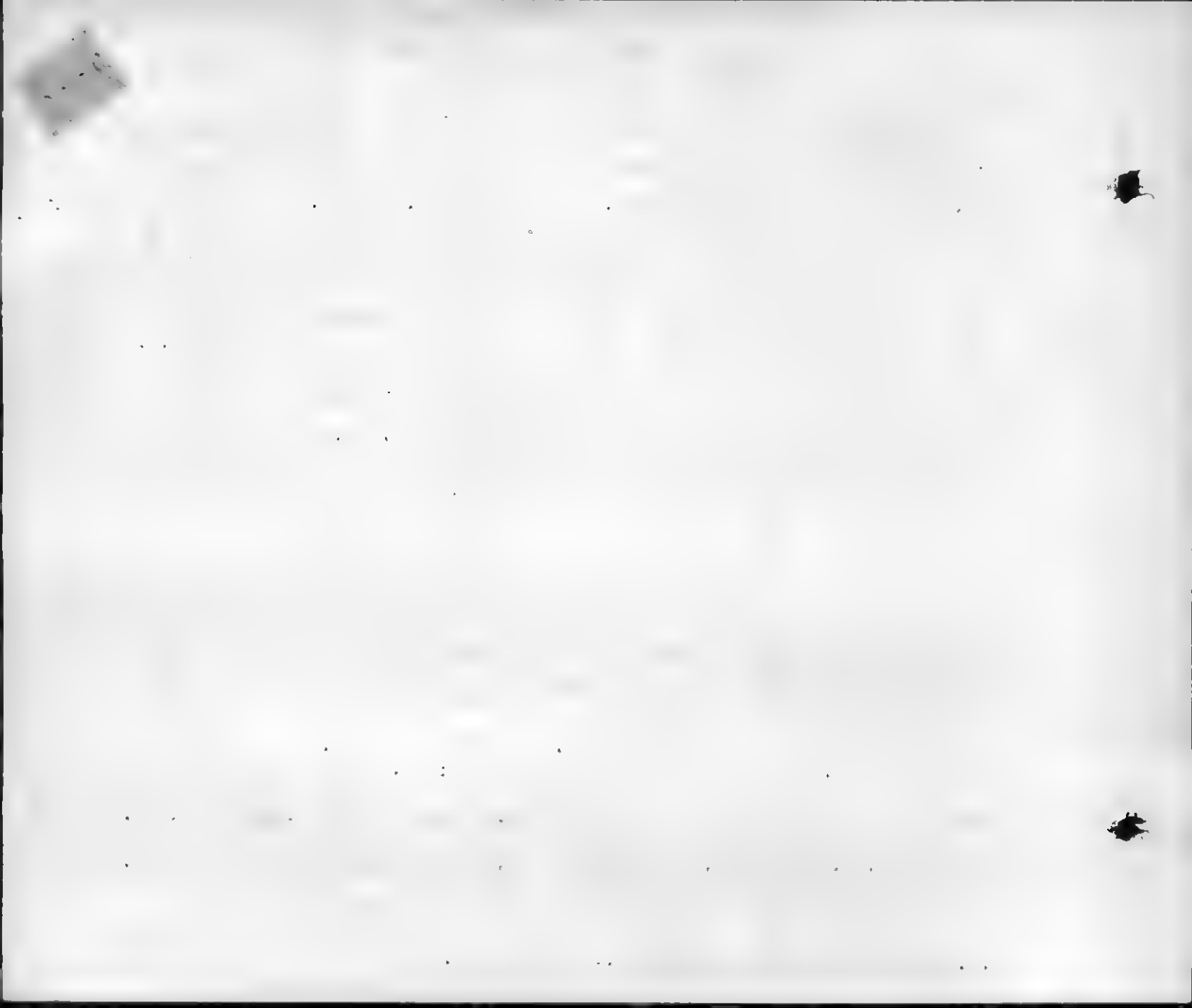
Reg. Dist. No. 215

10331

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Virginia b. COUNTY Norfolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 234 S. Blake Road	
3. NAME OF DECEASED (Type or print) First James Middle Rodreick Last CONGER		4. DATE OF DEATH Month September Day 23 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 June 1944
9. AGE (In years last birthday) 14 yrs		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Jackson CONGER		14. MOTHER'S MAIDEN NAME Lois Jane RODREICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT (Father) Henry J. Conger, (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 4 yrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 13 Sept. , 19 58 , to 23 Sept. , 19 58 , that I last saw the deceased alive on 23 Sept. , 19 58 , and that death occurred at 2:55 A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. C. Parke, Jr.		DATE SIGNED 9-23-58	
PHYSICIAN'S NAME (Type) J. C. PARKE, JR. LT MC USN		ADDRESS U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-58	
22c. NAME OF CEMETERY OR CREMATORY Norfolk, Virginia		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE F. A. Pumphrey		24a. REC'D BY REGISTRAR SEP 25 '58	
ADDRESS 1557 Wisconsin Ave., Bethesda, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

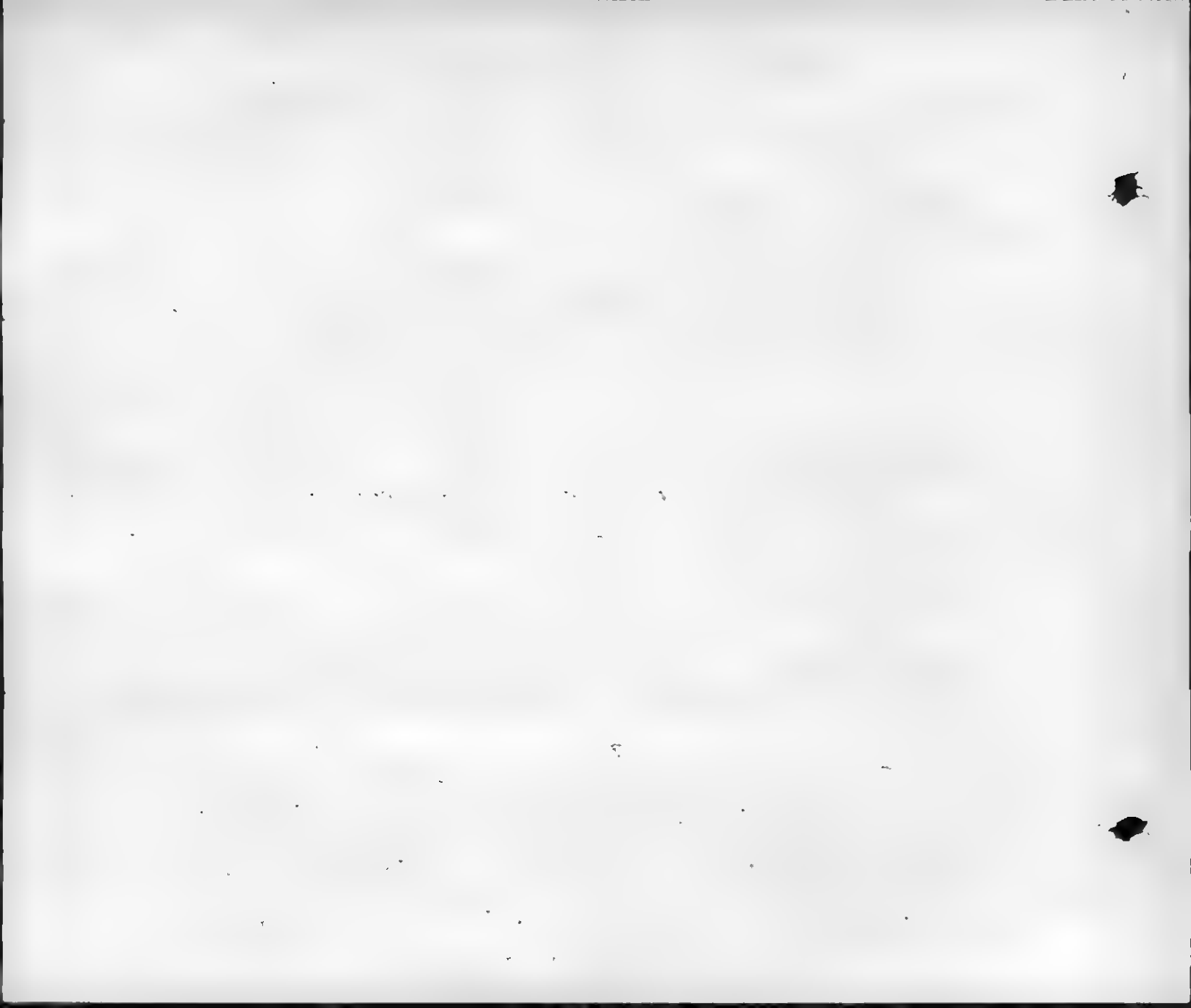
10294

10272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 ROCKVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium</u>				d. STREET ADDRESS <u>1 509 BILSCOT PLACE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Constance</u> First Middle Last				4. DATE OF DEATH <u>9</u> Month <u>6</u> Day <u>1958</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-2-58</u>	
9. AGE (In years last birthday) yrs. <u>4</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>George L. Cottman</u>				14. MOTHER'S MAIDEN NAME <u>Norma Katherine Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Patient's chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> DUE TO <u>0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cause unknown</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>58</u> , to <u>9/6/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/6</u> , 19 <u>58</u> , and that death occurred at <u>2:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard M. Auld</u> M.D.				ADDRESS (Street, city or town, state) <u>809 View Hull Rd. Rockville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD M. AULD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>...</u>			



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10295

10273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		1615-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hosp.</u>		d. STREET ADDRESS <u>7981 18th Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Blaine Walker Covington</u>		4. DATE OF DEATH <u>9 10 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>7-23-58</u>	9. AGE (In years last birthday) <u>—</u> yrs <u>1</u> month <u>18</u> days <u>18</u> hours <u>—</u> min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Octavius M. Covington</u>		14. MOTHER'S MAIDEN NAME <u>Regina B. Barbella</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>supper Respiratory Infection</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	
ADDRESS <u>2224-Wis. AVE NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CRAVEN				4. DATE OF DEATH Month Day Year SEPT. 16 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/10		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE MAN			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME BLANCHE (unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 44-4 DUE TO Malignant hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 14, 1958 , to Sept 16, 1958 , that I last saw the deceased alive on Sept 15, 1958 , and that death occurred at 8:10 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE G. Bowditch Hunter Jr.							
PHYSICIAN'S NAME (Type) BOWDITCH HUNTER JR. 809 Viers Mill Road Rockville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9/19/58	22c. NAME OF CEMETERY OR CREMATORY HAMILTON Cemetery		22d. LOCATION (City, town, or county) (State) HAMILTON VA.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. Elsie B. J. L. Hunt Leesburg VA			24a. REC'D BY REGISTRAR DATE NOV 5 58		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10333 CERTIFICATE OF DEATH

10296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Lewisdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilea Nursing Home		/d. STREET ADDRESS 7301 23rd. Ave.	
3. NAME OF DECEASED (Type or print) JOHN CRAWFORD		4. DATE OF DEATH September 17, 1958.	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1878
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Store clerk	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Crawford		14. MOTHER'S MAIDEN NAME Thelma Johns.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs Thelma E John -	
17. INFORMANT Mrs Thelma E John -		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basal Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 38 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 14, 1958 to Sept 17, 1958 that I last saw the deceased alive on Sept 16, 1958 , and that death occurred at 7:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John E. Jones M.D.		ADDRESS (Street, city or town, state) 1917 Seminary Rd. 9-17-58	
PHYSICIAN'S NAME (Type) John E. Jones		DATE SIGNED Sept 17, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-20-58	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Bladensburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.		24a. REC'D BY REGISTRAR SEP 19 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10334 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 85 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Wade Last Davis		4. DATE OF DEATH Month September Day 23 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1894
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Private Industry	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Oliver Davis		14. MOTHER'S MAIDEN NAME Minnie Prosperi	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Yes (If yes, give year or dates of service) WWI		16. SOCIAL SECURITY NO 578-24-7820	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis, Acute Leukemia (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 30 19 58 to September 23 19 58 that I last saw the deceased alive on September 23 19 58 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/24/58 ACTUAL SIGNATURE Leonard Garren M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Leonard Garren, M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 25, 1958	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Va
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Linnells ADDRESS Arlington, Va		24a. REC'D BY REGISTRAR DATE SEP 25 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10299

FOR STATE
HEALTH DEPT.

Item 14, Film 6-44, 10/6/58

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 10335 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut. on, Residence before admission) a. STATE MD b. COUNTY MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
c. LENGTH OF STAY IN 1b 1/2 hr.		d. STREET ADDRESS 1001 FOREST BLVD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2210 PINEY BRANCH RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD NORMAN DIETLE		4. DATE OF DEATH Month SEPTEMBER Day 29 Year 19 58	
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/16
9. AGE (in years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD JACOB DIETLE		14. MOTHER'S MAIDEN NAME Matilda Elizabeth Suanay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Erwin Dietle 10012 Portland Rd. Silver Spring, Md	
17. INFORMANT Erwin Dietle 10012 Portland Rd. Silver Spring, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & Laceration DUE TO (b) Bullet wound thru skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Found dead in rear room of restaurant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Self inflicted bullet wound thru skull			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Self inflicted bullet wound thru skull	
20c. TIME OF INJURY Month, Day, Year 9/29/ 58 Hour ? a.m. ? p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BUTCH'S GRILL		20f. (City or town) (County) (State) SILVER SPRING, MARYLAND, MD.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Bruchart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BRUCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/1/58	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		24a. REC'D BY REGISTRAR SEP 30 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10336

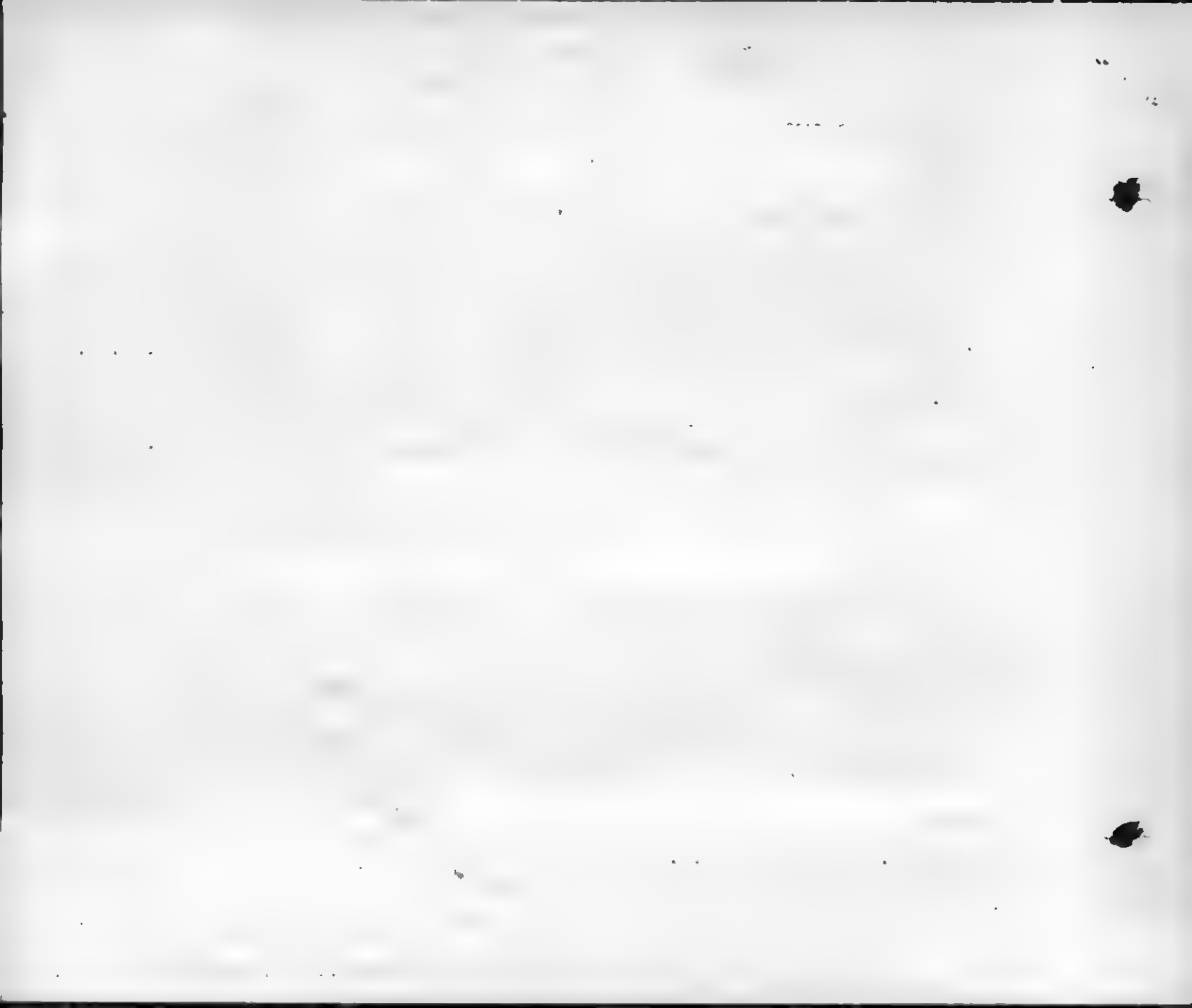
CERTIFICATE OF DEATH

10300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>156 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4415 Montgomery Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROBERTO</u> Middle <u>ITALO</u> Last <u>DONADEI</u>				4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 30, 1919</u>	
9. AGE (In years last birthday) <u>38</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Translator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Argentine Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Argentina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Valerio Donadei</u>			
14. MOTHER'S MAIDEN NAME <u>Josefa Dapero</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>Unascertainable</u>			
16. SOCIAL SECURITY NO. <u>679-42-2233</u>				17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Isotocarcinoma, primary in testis</u> <u>178X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I attended the deceased from <u>April 4</u> <u>1958</u> , to <u>September 7</u> <u>1958</u> , that I last saw the deceased alive on <u>September 7</u> <u>1958</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>(9/8/58)</u> ACTUAL SIGNATURE <u>G. Richard Lee</u> M.D. <u>The Clinical Center</u> PHYSICIAN'S NAME (Type) <u>G. RICHARD LEE, M.D.</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>William L. Knecht</u>			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P. 4</u>	
b. CITY OR TOWN (If outside corporate limits, write R.U.F.A. and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hyge 1</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>2110 Keating St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Russell (H.M.N.) Donaldson</u>		4. DATE OF DEATH <u>Sept 17 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/96</u>
9. AGE (In years, last birthday) <u>62 yrs</u>		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> M. n. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retiree</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>M. S. C.</u>	
13. FATHER'S NAME <u>Edward Donaldson</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE EMMERTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO <u>UNK</u>	
17. INFORMANT <u>Hosp. Record</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rt. Subdural hematoma and</u>			
<u>900.0</u> DUE TO (b) <u>left central contusion</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>fracture of skull</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell down steps at daughter's home 8404 Patoma Ave. College Pk md</u>	
20c. TIME OF INJURY <u>7:30 p.m.</u> Month <u>9</u> Day <u>13</u> Year <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) <u>College Pk</u> (County) <u>P. 4</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broesch</u>		DATE SIGNED <u>9-17-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROESCH</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>COLETT HILL CEM</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND RD. TO TR. COLS. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M.W. Chambers</u>		24a. REC'D BY REGISTRAR <u>SEP 22 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Cuthbert S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10337

CERTIFICATE OF DEATH

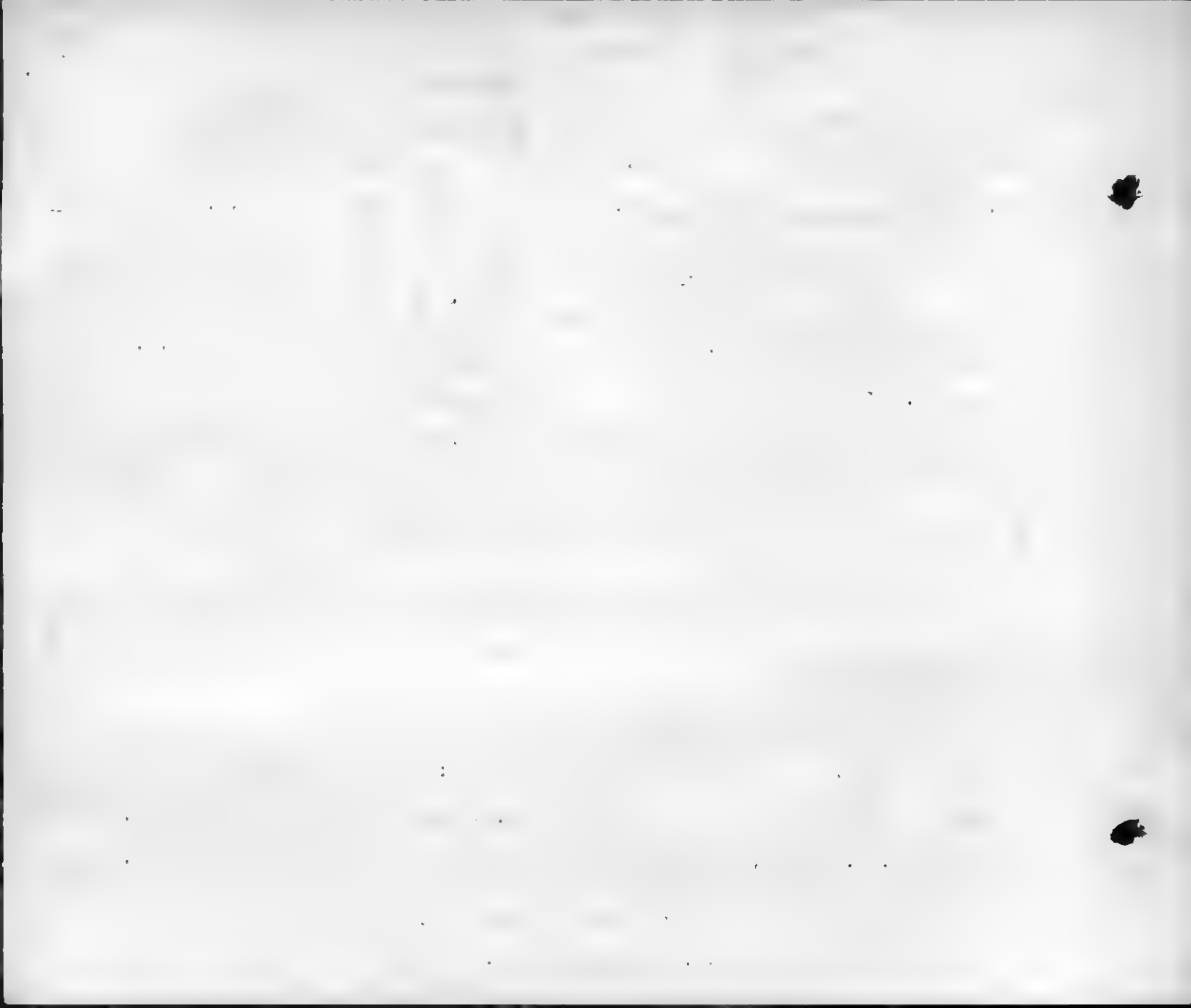
Reg. Dist. No.

10302

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 5 mos. 7 days		d. STREET ADDRESS 1214 33rd Street, N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Michael Last DREA		4. DATE OF DEATH Month September Day 8 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 May 1915
9. AGE (In years last birthday) 43 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Andrew J. DREA		14. MOTHER'S MAIDEN NAME Mary DWYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes 12-19-34 to 6-1-57		16. SOCIAL SECURITY NO 397 30 8785	
17. INFORMANT (Wife) Mrs. Audree Virginia DREA (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma, Left Lung 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 21 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 March , 19 58 , to 8 Sept. , 19 58 , that I last saw the deceased alive on 8 Sept. , 19 58 , and that death occurred at 9:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. J. Rupnik		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) E. J. RUPNIK, LCDR, MC, USN		DATE SIGNED 9-9-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Chambers #391		24a. REC'D BY REGISTRAR DATE SEP 10 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10303

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>9 yrs</u>		d. STREET ADDRESS <u>2615 Elmore St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2615 Elmore St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Henry Drury Jr.</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OF FACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-84</u>
9. AGE (In years last birthday) <u>74 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>advertising</u>	
10a. KIND OF BUSINESS OR INDUSTRY <u>Arment Co</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USE</u>		13. FATHER'S NAME <u>Geo. H. Drury</u>	
14. MOTHER'S MAIDEN NAME <u>Eliz. Leamon</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO <u>579-05-4259</u>		17. INFORMANT <u>Marie G. Heintz</u> Address <u>Stur 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschut</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschut</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 9 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden 162	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First John Middle Dunn Last Dunn		4. DATE OF DEATH Month Sept. Day 20 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1875
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Charlotte N. C.
13. FATHER'S NAME Mack Dunn		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Leonie Miller		Address Glenarden, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH 5 days
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiorenal disease (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 p. m.	20d. INJURY OCCURRED <input checked="" type="checkbox"/> while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 25, 1954 to Sept. 20, 1958 , that I last saw the deceased alive on Sept. 20, 1958 , and that death occurred at 3:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/22/58		
ACTUAL SIGNATURE Webster Sewell M.D.		
PHYSICIAN'S NAME (Type) Webster Sewell, M.D. Silver Spring, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/23/58	22c. NAME OF CEMETERY OR CREMATORY Glenarden, Md.
22d. LOCATION (City, town, or county) (State) Glenarden, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sward ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE SEP 26 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

~~White Pine~~

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10340

CERTIFICATE OF DEATH

10305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on- Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 4 mo. 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation				e. STREET ADDRESS 12415 Georgia Avenue			
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last Dwyer				4. DATE OF DEATH Month September Day 29 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/28/69	
9. AGE (In years last birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Proprietor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Dwyer				14. MOTHER'S MAIDEN NAME Martha E. Rainne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT William T. Martin 12611 Georgia Ave. Sil.Sp			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelitis. Bilateral DUE TO Prostatic Hypertrophy DUE TO Urinary Retention Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 4/1 , 19 58 , to 9/29 , 19 58 , that I last saw the deceased alive on 9/24 , 19 58 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird, M. D.				ADDRESS (Street, city or town, state) Sandy Spring, Md.			
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.				DATE SIGNED 9/29/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2 58		22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR 3 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

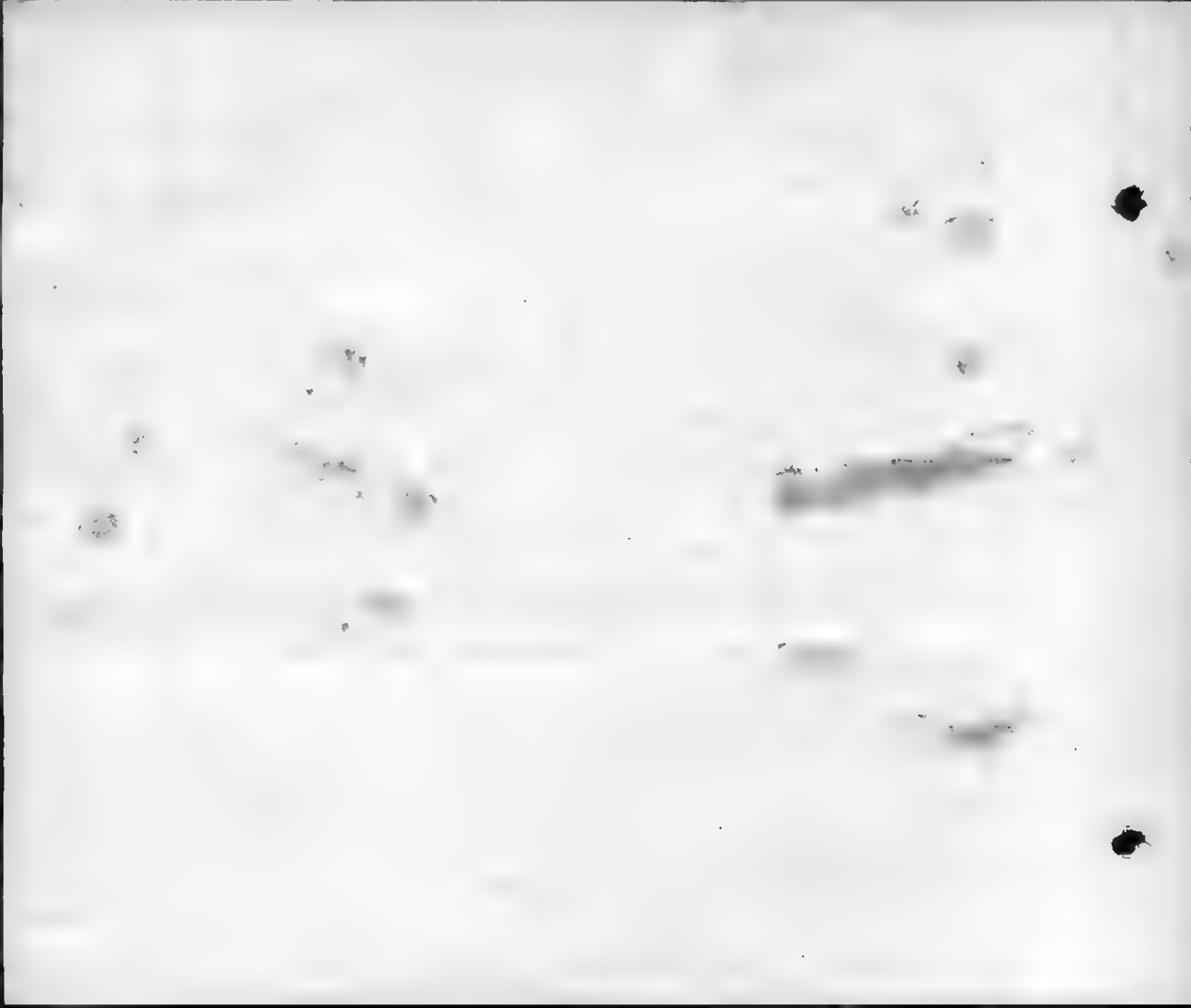
10341

CERTIFICATE OF DEATH

10306

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN IB <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hspt.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ellie Genevieve Edwards</u>				4. DATE OF DEATH <u>9</u> <u>4</u> <u>1958</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/70</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hugh Peden</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Hspt + Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Infarction, acute</u> DUE TO (b) <u>Cerebro-vascular accident-st.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/27</u> , 19 <u>58</u> , to <u>9-4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-3</u> , 19 <u>58</u> , and that death occurred at <u>5:25 A</u> .M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest A. Sarao</u>		ADDRESS (Street, city or town, state) <u>7006 New Hampshire Ave Takoma Park</u>		DATE SIGNED <u>9-4-58</u>			
PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 7, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Winston Salem, North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carrole Street NE</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



CERTIFICATE OF DEATH

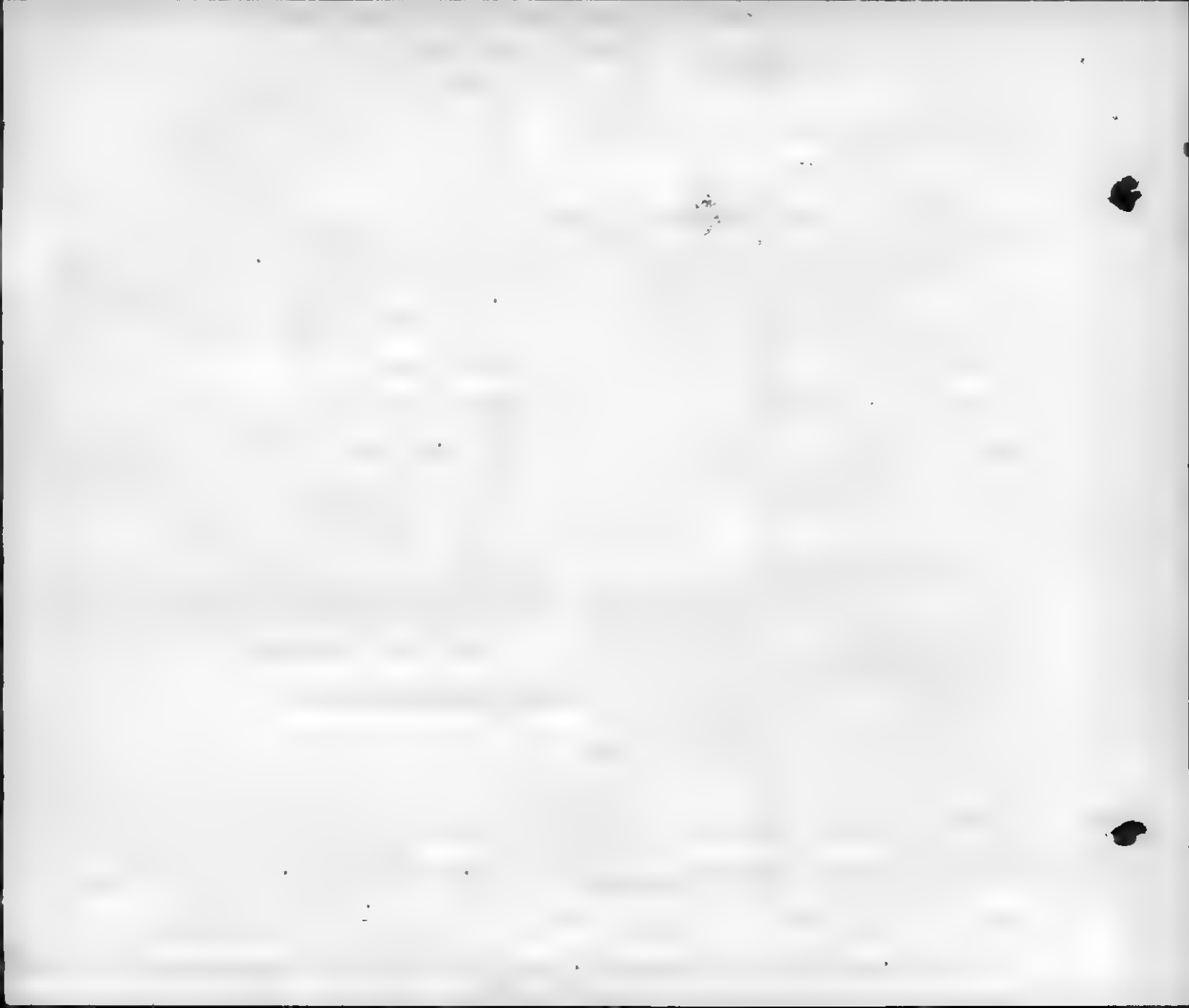
Reg. Dist. No.

10342

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3410 Shepherd Street		d. STREET ADDRESS 3410 Shepherd Street	
3. NAME OF DECEASED (Type or print) First Middle Last ELEANOR CRAVEN FISHBURN		4. DATE OF DEATH Month Day Year Sept. 1, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1907
9. AGE (In years last birthday) 51 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min 0 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Montana		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George W. Craven		14. MOTHER'S MAIDEN NAME Martha Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 530-19-6605	
17. INFORMANT Address Cyrus C. Fishburn-Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE STOMACH DILATATION DUE TO (b) INTESTINAL OBSTRUCTION DUE TO (c) METASTATIC CARCINOMA, PRIMARY UNDETERMINED UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 144 HRS. / 6 D. 2-3 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 14, 1958 , to SEPT. 1, 1958 , that I last saw the deceased alive on SEPT. 1, 1958 , and that death occurred at 4:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Duohy		ADDRESS (Street, city or town, state) 7720 Wisconsin Ave, Bethesda, Md	
PHYSICIAN'S NAME (Type) John H. Duohy		DATE SIGNED 9/1/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/3/58	
22c. NAME OF CEMETERY OR CREMATORY Spring Grove		22d. LOCATION (City, town, or county) (State) Cincinnati, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 4 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

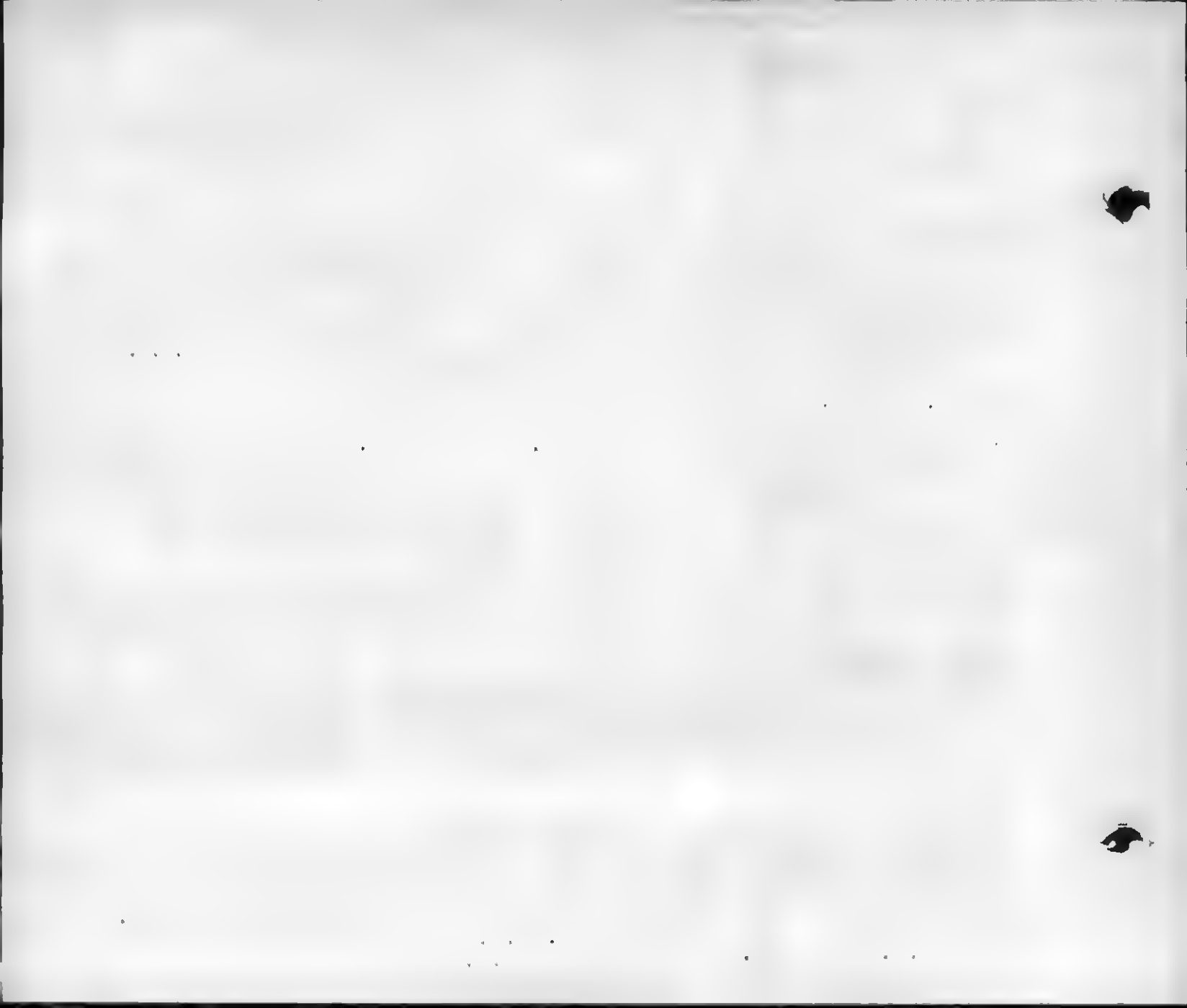
10307

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a STATE Maryland b COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. STREET ADDRESS 7400 Summit Avenue	
3. NAME OF DECEASED (Type or print) Emily Russell Ford		4. DATE OF DEATH September 10 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1930
9. AGE (in years last birthday) 27 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Rome, New York	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Dr. Edwin P. Russell		14. MOTHER'S MAIDEN NAME Mazie Shuler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO W. Kent Ford, Jr.	
17. INFORMANT Husband		Address As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema of lungs 241X DUE TO Conditions, if any, which gave rise to immediate cause (b) Bronchial asthma (c) stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-10-58	
22a. BURIAL CREMATION, REMOVAL (Spec. 1) removal		22b. DATE THEREOF 9/10/58	
22c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		22d. LOCATION (City, town, or county) (State) Clifton Forge, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR DATE SEP 11 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



10344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>				c. LENGTH OF STAY IN 1b <u>1 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5062 Aurora Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>INFANT PHILIP FRANZ</u>				4. DATE OF DEATH Month Day Year <u>Sept. 24 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4, 1957</u>	9. AGE (In years lost birthday) yrs. <u>11</u> <u>20</u>	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gerald J. Franz</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN MEEHAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>FATHER</u> Address <u>5002 Aurora Dr. Kens Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub Dural HEMATOMA</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Spontaneous Intracranial Hemorrhage</u> DUE TO (c) <u>INDEFINITE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October, 1957</u> to <u>Sept. 1958</u> , that I last saw the deceased alive on <u>Sept 23, 1958</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James M. Moser Jr.</u> M.D. <u>10001 E. BEXHILL Drive</u>				PHYSICIAN'S NAME (Type) <u>JAMES M. MOSER, Jr.</u> <u>Kensington, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey Funeral Home, Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10345

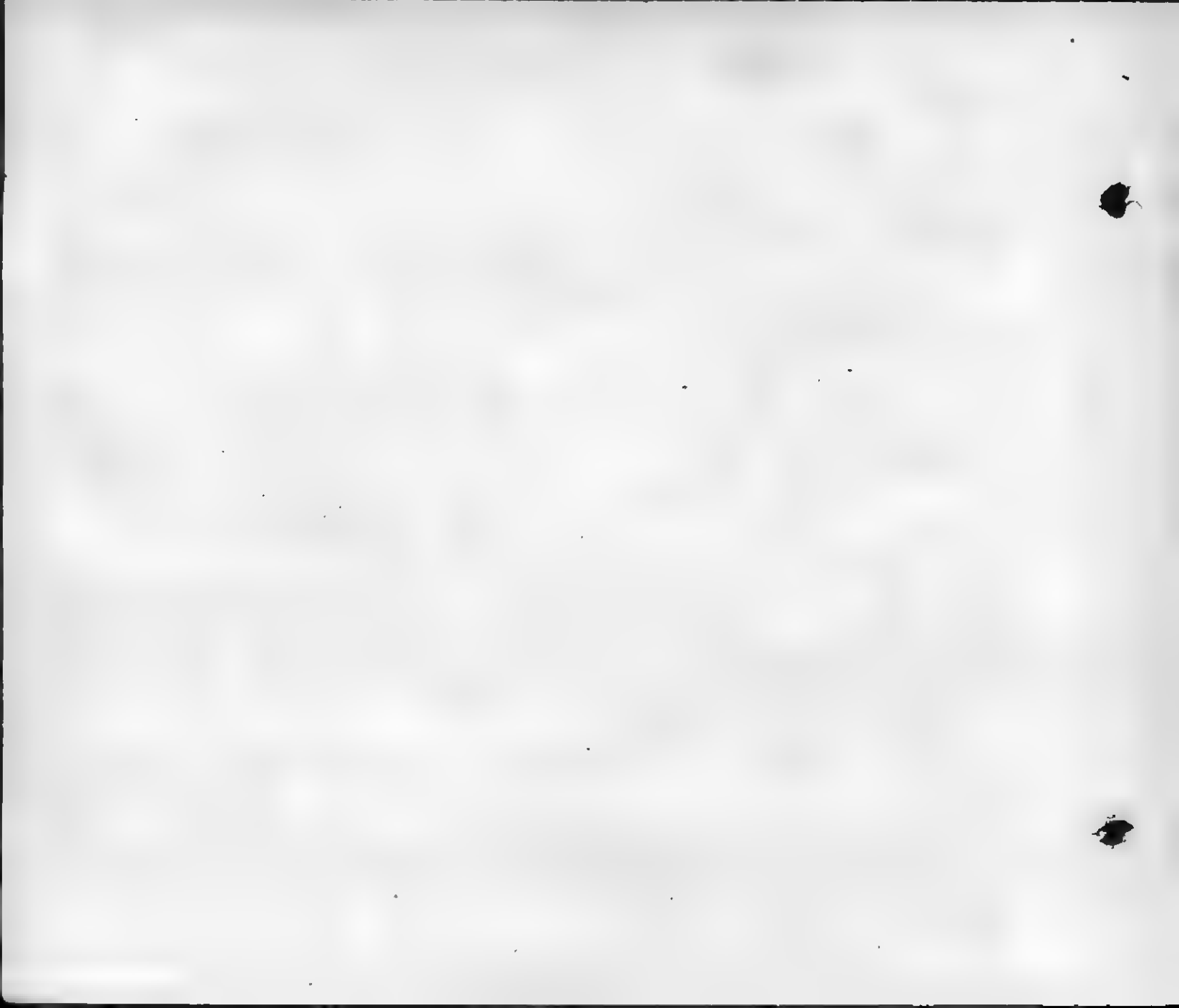
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookdale</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>None</u> <u>5013 Brookdale Road</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> <u>Brookdale</u>	
3. NAME OF DECEASED (Type or print) <u>Ethel</u> <u>Dodge</u> <u>Frost</u>		4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 June 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Laurel, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Carroll DeWilton Frost</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Dodge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>170</u>	
17. INFORMANT <u>Mrs Helen Robinson (Sister)</u>		Address <u>5013 Brookdale Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of ovary with</u> DUE TO <u>generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 1/2 years</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>26 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>26 Sept</u> , 19 <u>58</u> , and that death occurred at <u>10:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry A. Horstman Jr.</u>		ADDRESS (Street, city or town, state) <u>1835 Egest. NW Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Harry A. Horstman Jr.</u>		DATE SIGNED <u>26 Sept 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-29-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Phillips Church Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY,</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 30 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10276

CERTIFICATE OF DEATH

Reg. Dist. No. 10311

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's Hospital</u>				d. STREET ADDRESS <u>1100 ...</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Margaret</u> First <u>Ellen</u> Middle <u>Myton</u> Last <u>Ellen</u>				4. DATE OF DEATH <u>Sept 16</u> 19 <u>58</u> Month <u>Sept</u> Day <u>16</u> Year <u>19</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 31 1912</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u>	IF UNDER 24 HRS Hours <u>1</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph ...</u>				14. MOTHER'S MAIDEN NAME <u>Ellen ...</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1-10-114711</u>		17. INFORMANT <u>Mrs. L.H. ...</u>		Address <u>...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery of heart - thrombosis</u> <u>1st</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>None</u> DUE TO (c) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 16</u> , 19 <u>58</u> , to <u>Sept 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 16</u> , 19 <u>58</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>...</u> DATE SIGNED <u>...</u>							
ACTUAL SIGNATURE <u>...</u> M.D. <u>...</u>							
PHYSICIAN'S NAME (Type) <u>...</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-19-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral</u> ADDRESS <u>4812 Georgia Ave NW</u>				24a. REC'D BY REGISTRAR <u>SEP 17 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



10275

CERTIFICATE OF DEATH

10310

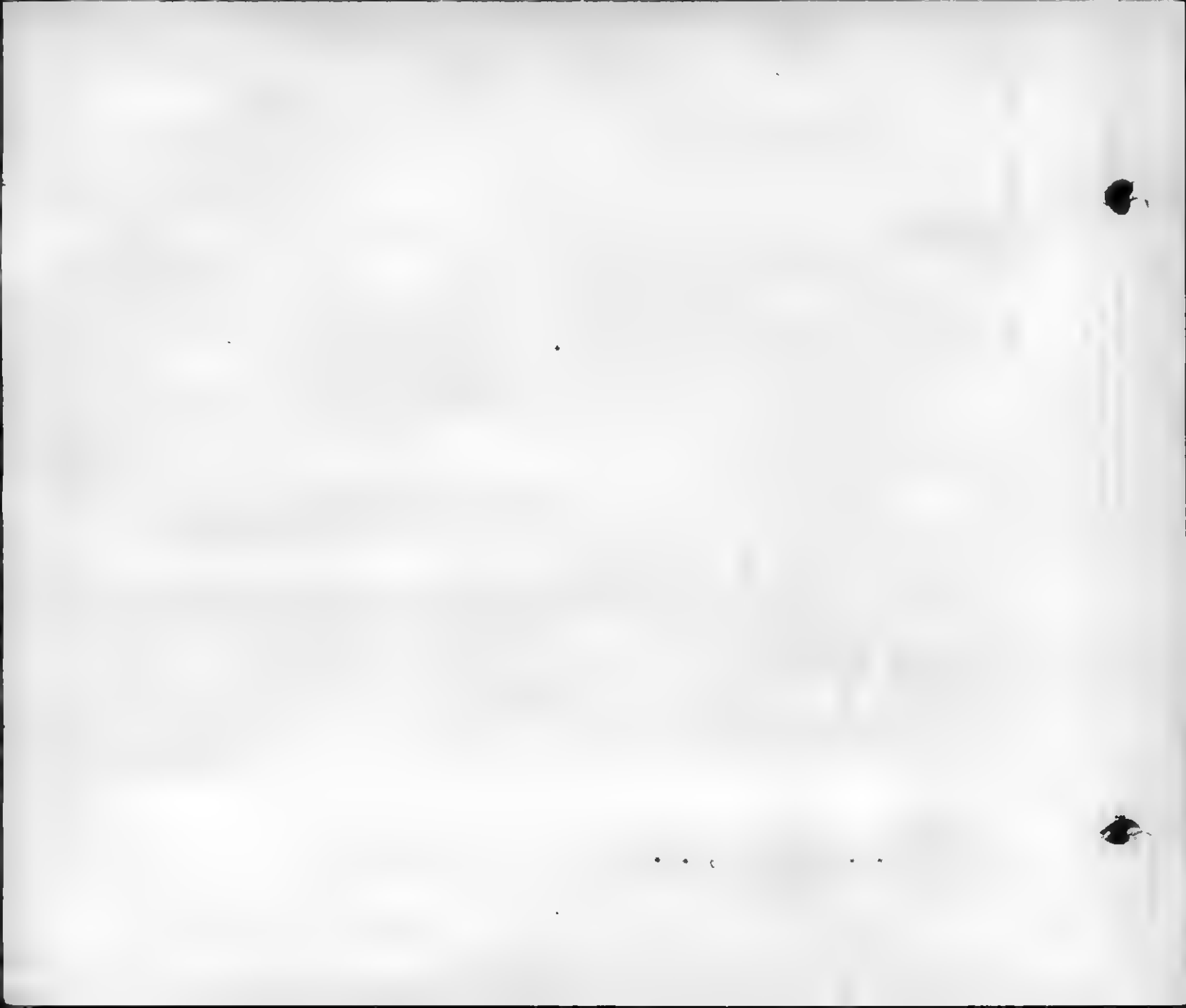
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>412 Ethan Allen Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>John Robert Gallahan</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>29</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-76</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>26</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Fireman FIRE DEPT.</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
13. FATHER'S NAME <u>Samuel Gallahan</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE, ACUTE, MASSIVE, RETROPERITONEAL</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>(b) RUPTURED ABDOMINAL AORTIC ANEURYSM.</u> DUE TO <u>(c) GENERALIZED ARTERIOSCLEROSIS.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>1 DAY</u> <u>YEARS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Sept. 22, 1958</u> to <u>Sept. 23, 1958</u> that I last saw the deceased alive on <u>Sept. 23, 1958</u> and that death occurred at <u>11:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. F. Thibadeau</u>				M.D. <u>10111 Colossville Rd.</u>			
PHYSICIAN'S NAME (Type) <u>A. F. THIBADEAU, M.D.</u>				Address <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>SEPT. 26, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>	22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hysong</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>

(MARTIN W. HYSONG COMPANY)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

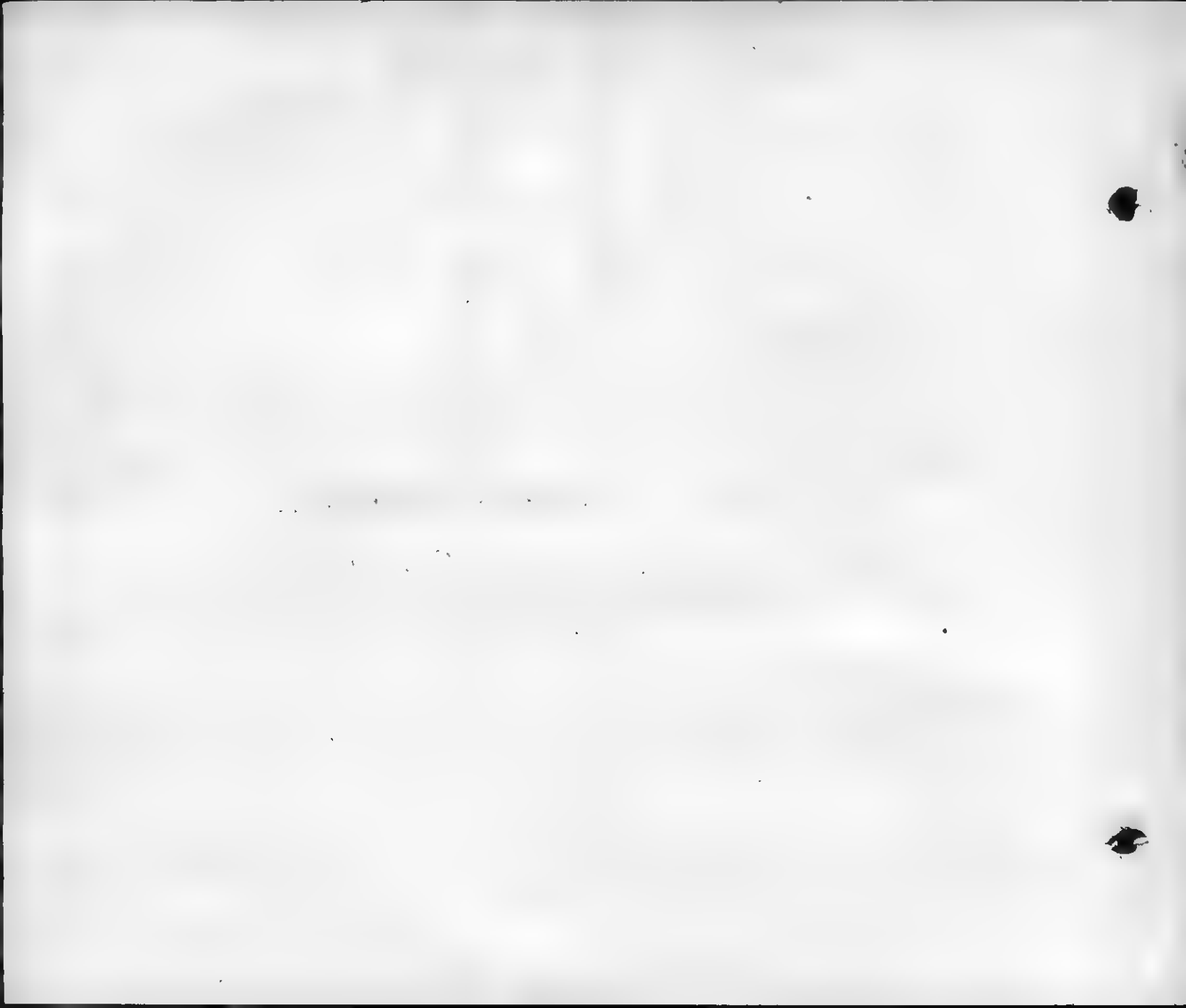
10277

CERTIFICATE OF DEATH

Reg. Dist. No. 10312

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Long Island - Bellrose</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN IT <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Island - Bellrose</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>79-50 270th. St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mathew</u> Middle <u>Frank</u> Last <u>Gallo</u>				4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-87</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Gallo</u>				14. MOTHER'S MAIDEN NAME <u>Genevieve Calasie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>117-03-5141</u>		17. INFORMANT <u>Chart</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Burcho-pneumonia - Terminal</u>						<u>12 day</u>	
900.0 DUE TO (b) <u>Uremia</u>						<u>3 day</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Primary carcinoma of ureter and prostate</u>						<u>15 day</u>	
(c) <u>multiple fractures due to accident</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, Fractures, pyelonephritis (Diabetic mellitus)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>PT. fell in Home of Relatives Down Basement Steps</u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year, Hour, o. m. <u>12 30 8-26-58</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Takoma Park, Montgomery, Md</u> (County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>8-26-58</u> , 19 <u>58</u> , to <u>9-10-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-9-58</u> , 19 <u>58</u> , and that death occurred at <u>8:25</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Recharl H. Clapp</u> M.D.				ADDRESS (Street, city or town, state) <u>1600 Carroll Ave. Takoma Park, Md</u> DATE SIGNED <u>9-10-58</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LONG ISLAND CEM.</u>		22d. LOCATION (City, town, or county) <u>N.Y. NY</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jo. Hawkes Sons Inc.</u> ADDRESS <u>1186 R. Ave NW</u>				24a. REC'D BY REGISTRAR <u>SEP 15 '58</u> DATE <u></u>		24b. REGISTRAR'S SIGNATURE <u>Clara - Hous</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



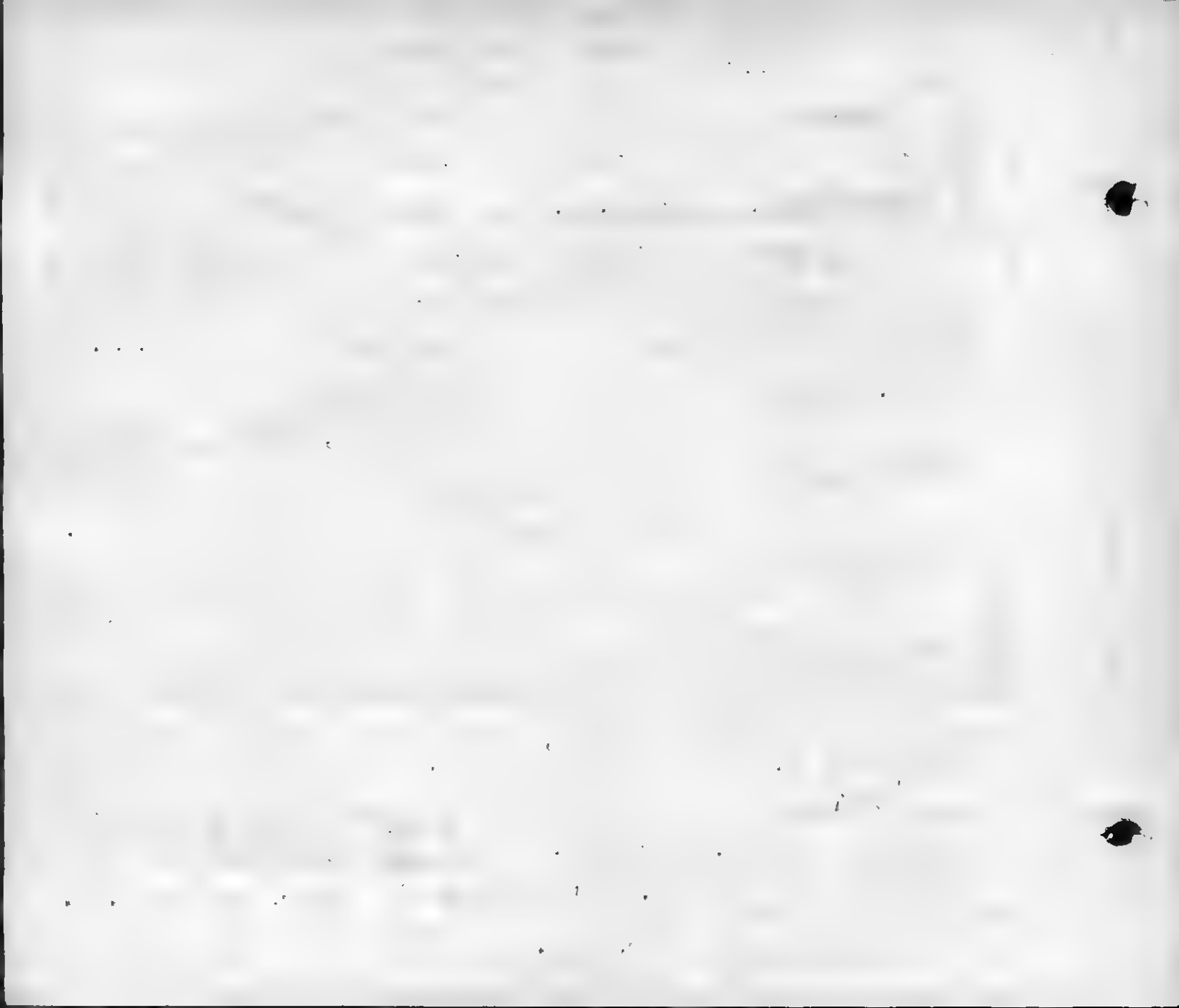
10346

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 47 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1904 Graham Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Thomas Middle Michael Last Geiger				4. DATE OF DEATH Month September Day 17 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 14, 1949	
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas L. Geiger				14. MOTHER'S MAIDEN NAME Helen Dashko			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Septicemia							
DUE TO (b) Lymphocytic Leukemia							
DUE TO (c) 10 wks.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 1, 1958 to September 17, 1958 that I last saw the deceased alive on September 17, 1958 and that death occurred at 10:00 A. M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Nathan S. Taylor M.D.				The Clinical Center 9-17-58			
PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 20, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Roman Catholic		22d. LOCATION (City, town, or county) (State) Windber, Somerset Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Meek				ADDRESS Windber, Penna.		24a. REC'D BY REGISTRAR SEP 22 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10347

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>17807-Buckyard Rd.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
4. NAME OF DECEASED (Type or print) First Middle Last <i>Daniel J. Goldberg</i>				4. DATE OF DEATH Month Day Year <i>Sept. 27 1958</i>			
5 SEX <i>M</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 27, 1920</i>	9. AGE (In years last birthday) <i>38</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto mechanic</i>				10b. KIND OF BUSINESS OR INDUSTRY			
11 BIRTHPLACE (State or foreign country) <i>Albany, N.Y. U.S.A.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Harry Goldberg</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Moskowitz</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. <i>154-64-1111</i>			
17. INFORMANT <i>Morton Goldberg</i>				Address <i>154-64-1111</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i>				<i>2 1/2 hrs.</i>			
587.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) <i>acute myocarditis</i>			
				(c) <i>acute fibrous pericarditis</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>9/20/58</i> , 1958, to <i>9/27/58</i> , 1958, that I last saw the deceased alive on <i>9/27/58</i> , and that death occurred at <i>4:25 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Hopkins N. Jones</i> M.D.				ADDRESS (Street, city or town, state) <i>Rockville, Md.</i> DATE SIGNED <i>9/27/58</i>			
PHYSICIAN'S NAME (Type) <i>HOPKINS N. JONES</i>				ROCKVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>9/28/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>KING DAVID CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>FALLS CHURCH, VA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Lawrence Jones</i> ADDRESS <i>Wash. D.C.</i>				24a. REC'D BY REGISTRAR <i>SEP 29 '58</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10315

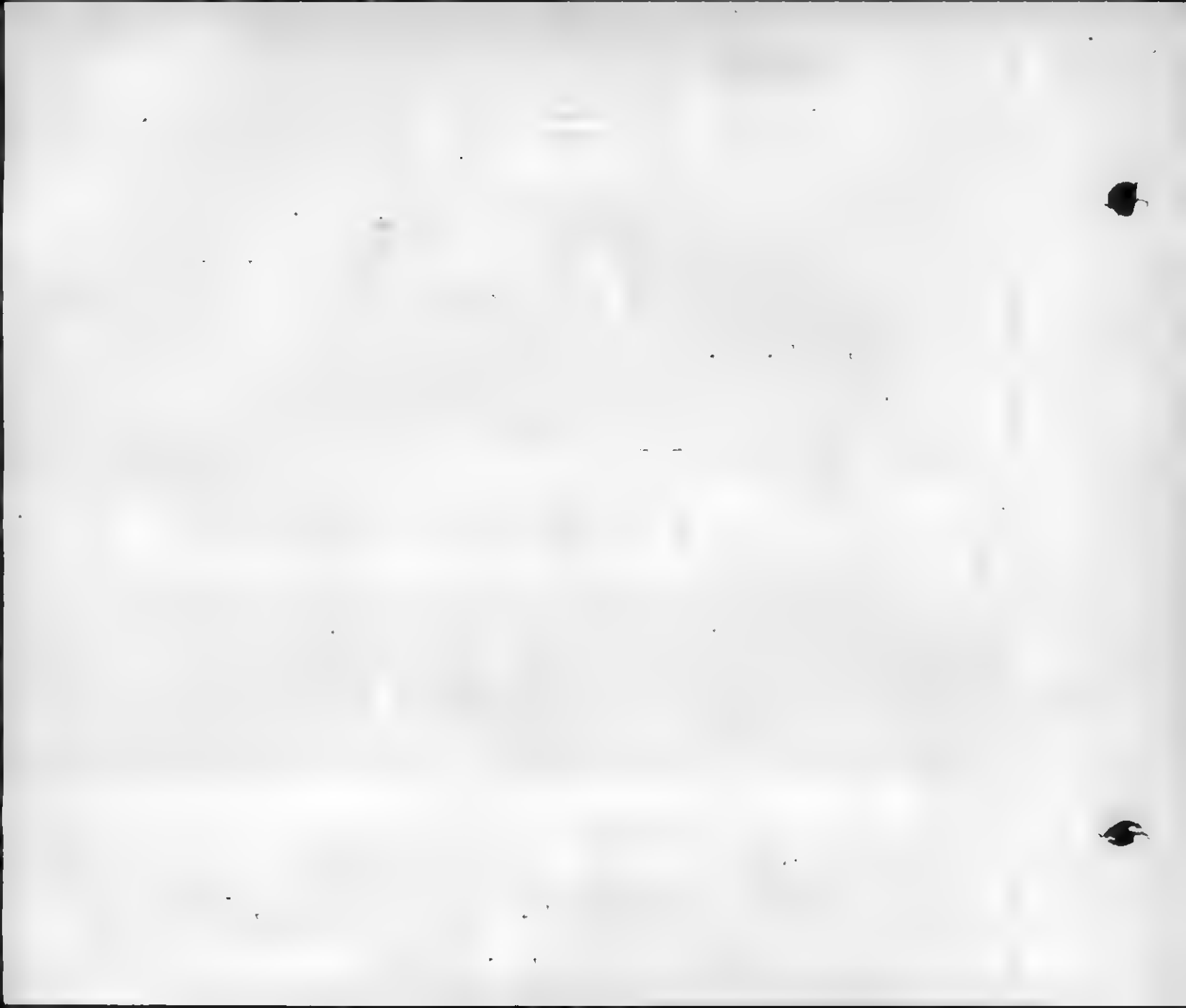
10348

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Porter</u>		c. LENGTH OF STAY IN 1b <u>Found Road</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Noewood Rd</u>				d. STREET ADDRESS <u>13210 Georgia Ave.</u>			e. IS RES. DENIED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Maiben Ernest Gordon</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/16/14</u>	9. AGE (in years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ass't. Mgr.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John H. Gordon</u>				14. MOTHER'S MAIDEN NAME <u>Christine Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW #2 579-05-7005</u>		17. INFORMANT <u>Joseph R. Gordon</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Carbon monoxide poisoning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in auto.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Body badly decomposed. Apparently dead for about 2 wks. when found</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Case attached from exhaust extending into car</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/26/58</u>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 30 1958</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Huns</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10316

10349

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>1025 224 Granlin Avenue, Rockville</u>	
3. NAME OF DECEASED (Type or print) <u>UPTON EUGENE GRANT</u>		4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1930</u>
9. AGE (in years last birthday) <u>27</u> yrs		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>10</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Grant</u>		14. MOTHER'S MAIDEN NAME <u>Bessie McKilvey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>Marines</u>		16. SOCIAL SECURITY NO. <u>573-34-9915</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary thrombosis</u> 910.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Rupture Rt. pulmonary artery</u> (c) <u>Due to</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pushing fallen tree (with bulldozer) which snapped back and hit him.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> a. m. <u>9-3</u> p. m. <u>1958</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Parkland Hill Rd</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>SEP 5 '58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Bethesda, Maryland</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

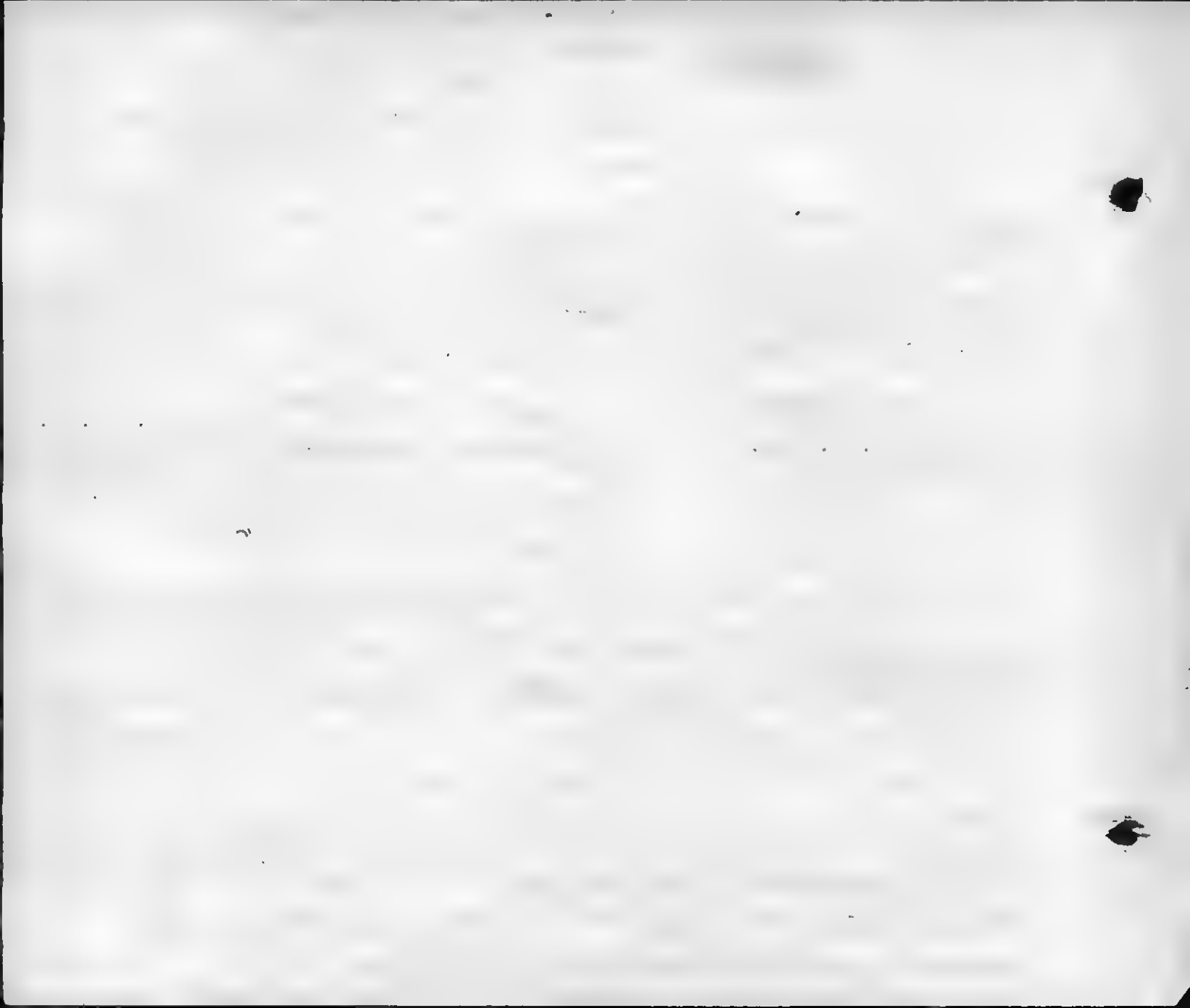


CERTIFICATE OF DEATH

Reg. Dist. No.

10297

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 6 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverly Sanitarium				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
3. NAME OF DECEASED (Type or print) WILLIAM First HENRY Middle GREENLEAF Last				4. DATE OF DEATH Month 9/14/1958 Day 19 Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 15, 1883	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer (retired)	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Greenleaf		14. MOTHER'S MAIDEN NAME -----Lane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes Sp. Am. War.		16. SOCIAL SECURITY NO 340-10-0532		17. INFORMANT (daughter) Virginia Greenough		Address Wash., D. C. 5020 Palisade Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE SOIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 10 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARKINSON'S DISEASE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 5, 1958 to Sep 14, 1958 , that I last saw the deceased alive on Sep 13, 1958 , and that death occurred at 3:43 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Hill Carter				ADDRESS (Street, city or town, state) 1835 Eye St NW Washington DC			
PHYSICIAN'S NAME (Type) HILL CARTER				DATE SIGNED Sep 14, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-15-1958		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bawlers Sons				ADDRESS Washington, D. C.		24a. REC'D BY REGISTRAR DATE SEP 16 '58	
				24b. REGISTRAR'S SIGNATURE C. L. & H. S.			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10350

CERTIFICATE OF DEATH

Reg. Dist. No.

10318

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN TB <u>15 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>117 UNIVERSITY BLVD. WEST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>CECIL</u> Last <u>GRETTON</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 21, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMMERICAL ARTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>ENGLAND</u> ✓	
13. FATHER'S NAME <u>HENRY GRETTON</u>		14. MOTHER'S MAIDEN NAME <u>WACE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>037-01-7305</u>	
17. INFORMANT <u>WENEC. GRETTON</u>		Address <u>AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) <u>GENERAL ATHEROSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC ATRICULAR FIBRILLATION - CARDIOMEGALY</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>NOV. 1957</u> to <u>SEP. 27, 1958</u> , that I last saw the deceased alive on <u>SEP. 27, 1958</u> , and that death occurred at <u>9:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Roberts</u>		ADDRESS (Street, city or town, state) <u>8907 GEORGIA AVENUE</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		DATE SIGNED <u>SEP 27, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>9/27/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jiska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>SEP 29 58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10351

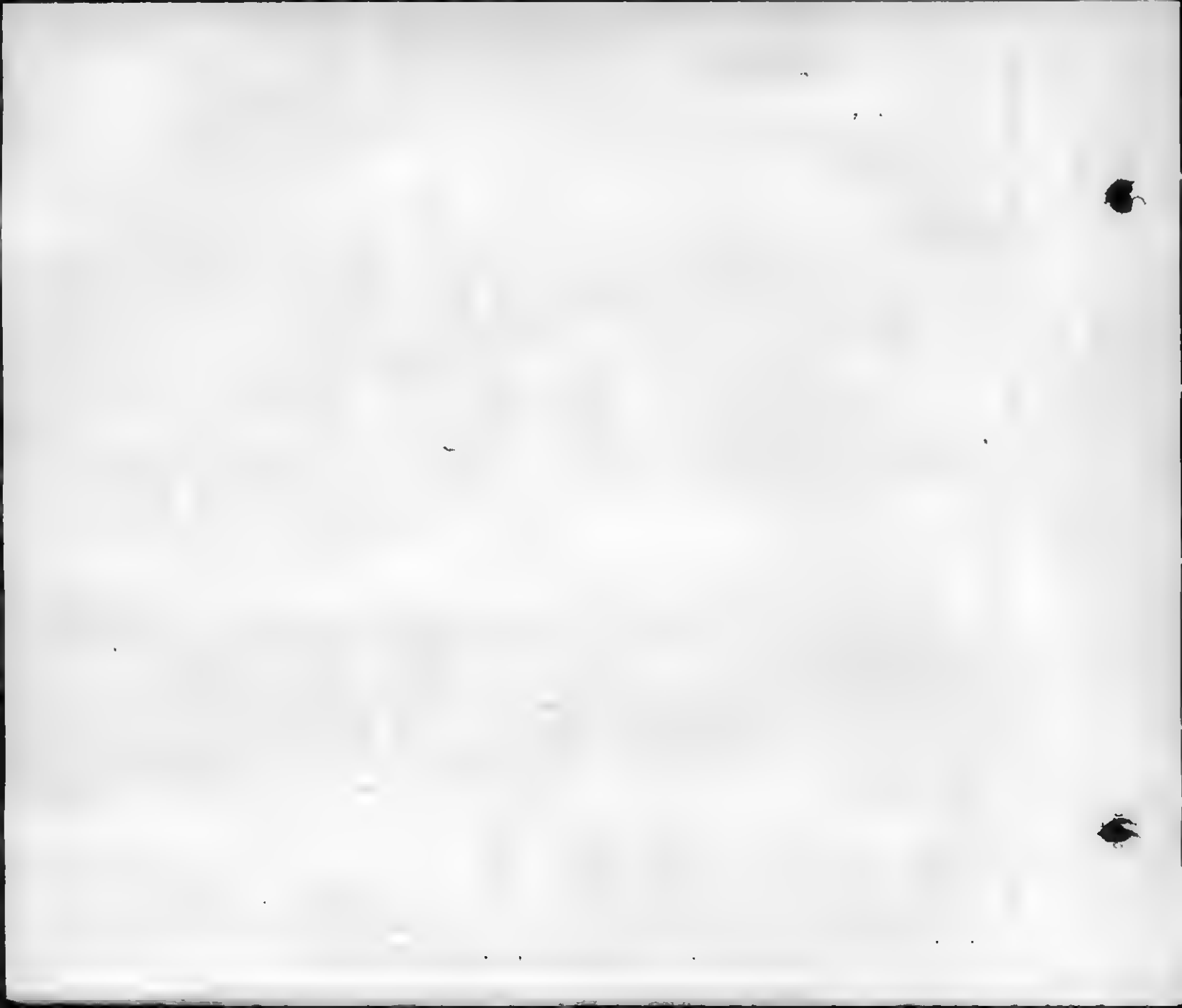
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>9536 E. Beekhill</u>			
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>L.</u> Last <u>GRISAMORE</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3 '94</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng. R.R. Rd.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas GRISAMORE</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Nelson GRISAMORE</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Standstill</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>Sept. 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 17</u> , 19 <u>58</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Milton Gysack</u> M.D. <u>1302 - 15th N.W., Wash. D.C.</u>				DATE SIGNED <u>9/17/58</u>			
PHYSICIAN'S NAME (Type) <u>Milton Gysack</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Mountcastle</u> ADDRESS <u>Box 65 Alexandria, Va.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove card.



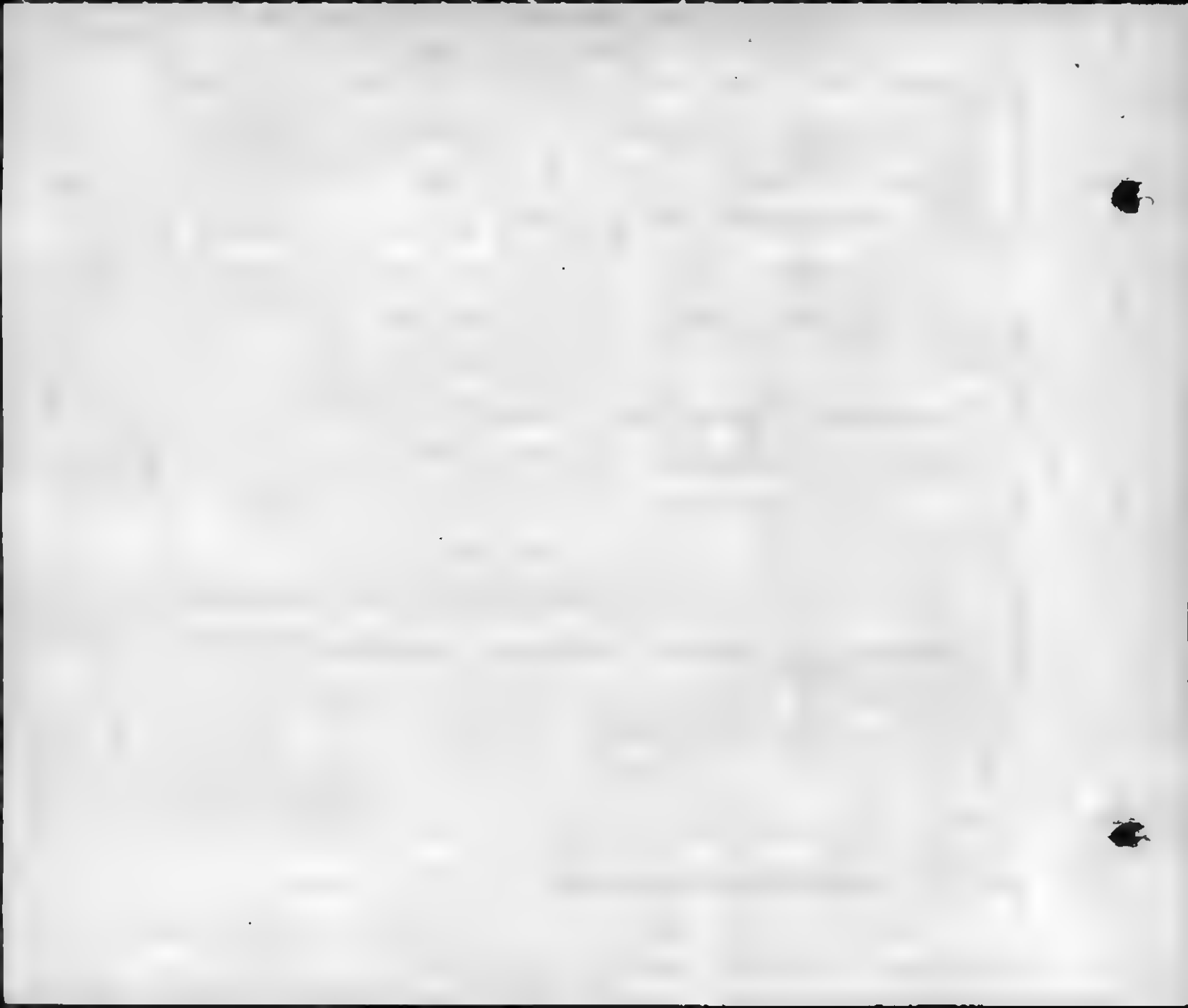
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10278 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

10320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sanitarium + Hosp</u>				d. STREET ADDRESS <u>1 Conn. Ave. + Bradley Lane</u>			
3. NAME OF DECEASED (Type or print) <u>William Gerard Groesbeck</u>				4. DATE OF DEATH <u>Sept. 10 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/1/94</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Herman J. Groesbeck</u>				14. MOTHER'S MAIDEN NAME <u>Lizbeth Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>WW Navy None</u>				16. SOCIAL SECURITY NO. <u>Med. records</u>			
17. INFORMANT <u>Med. records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiac Failure</u> <u>13X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Broncho-pneumonia</u> DUE TO (c) <u>Anemia - Secondary Severe</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>1 week</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bleeding of Bowel-Large.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-18-</u> , 19 <u>58</u> , to <u>9-10-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-10-</u> , 19 <u>58</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>9/10/58</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>SEP 16 58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert A. Hare</u>	



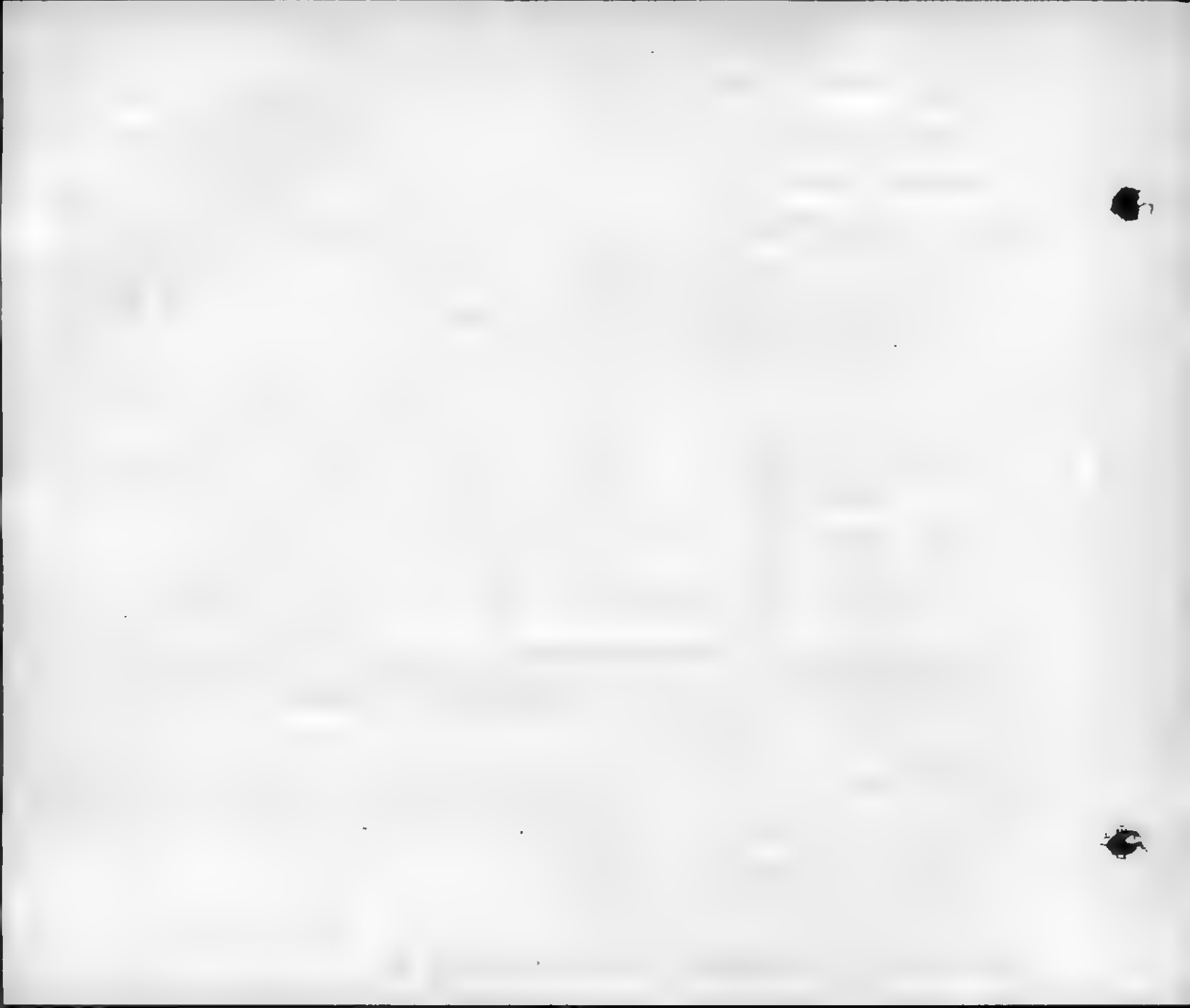
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10279

CERTIFICATE OF DEATH

Reg. Dist. No. 10321

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium</u>		e. STREET ADDRESS <u>17417 Carroll Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>ANN</u> Last <u>GROSSMAN</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Newish</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
13. FATHER'S NAME <u>Theodore Brown</u>		14. MOTHER'S MAIDEN NAME <u>Hannah GlusTone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Hospital Records</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>years?</u> <u>years?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> to <u>Sept 2</u> , 1958, that I last saw the deceased alive on <u>Sept 1</u> , 1958, and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7600 Carroll Ave. Tak. Park, Md. 9/2/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. HARE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/3-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nat Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>		ADDRESS <u>4217 9th St NW</u>	
24a. REC'D BY REGISTRAR <u>SEP 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Conrad S. Kinn</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10352

CERTIFICATE OF DEATH

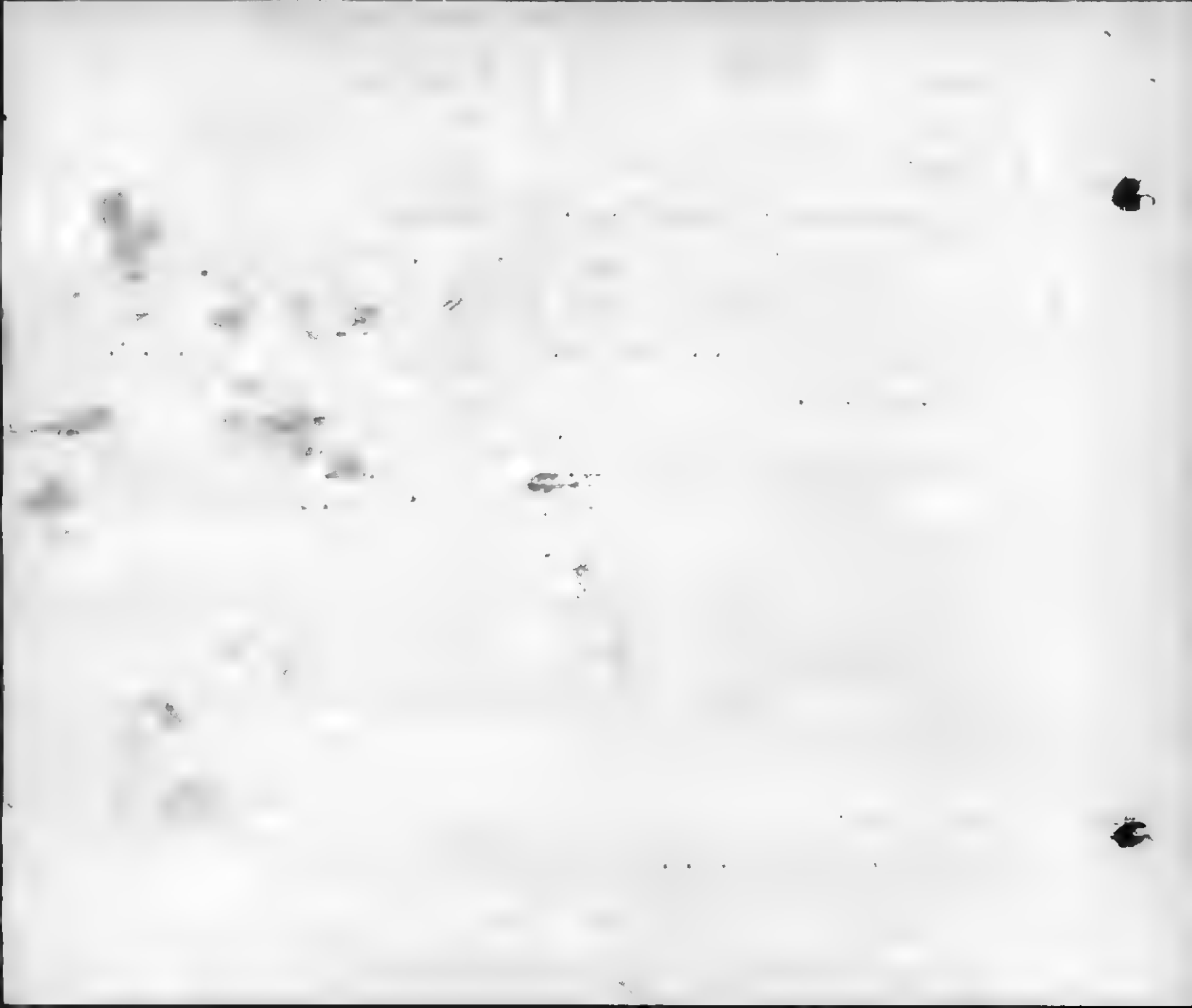
Reg. Dist. No.

10322

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Louisiana b. COUNTY Orleans	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Orleans	
c. LENGTH OF STAY IN Tb 98 days		d. STREET ADDRESS 2732 Dreux Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William (none) Gunn, Jr.		4. DATE OF DEATH Month Day Year September 8, 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 2, 1889
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 9 6	11. IF UNDER 24 HRS Hours Min 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Supply Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Supply	
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Gunn, Sr.		14. MOTHER'S MAIDEN NAME Margaret Annie McGary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes WW I		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pharynx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 19 58 to September 8, 19 58 , that I last saw the deceased alive on September 8, 19 58 , and that death occurred at 5:31 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Richard Lee		DATE SIGNED 9/8/58	
PHYSICIAN'S NAME (Type) G. RICHARD LEE, M.D.		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/9/58	
22c. NAME OF CEMETERY OR CREMATORY Meterie Cemetery		22d. LOCATION (City, town, or county) (State) Orleans Parish, New Orleans	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10353

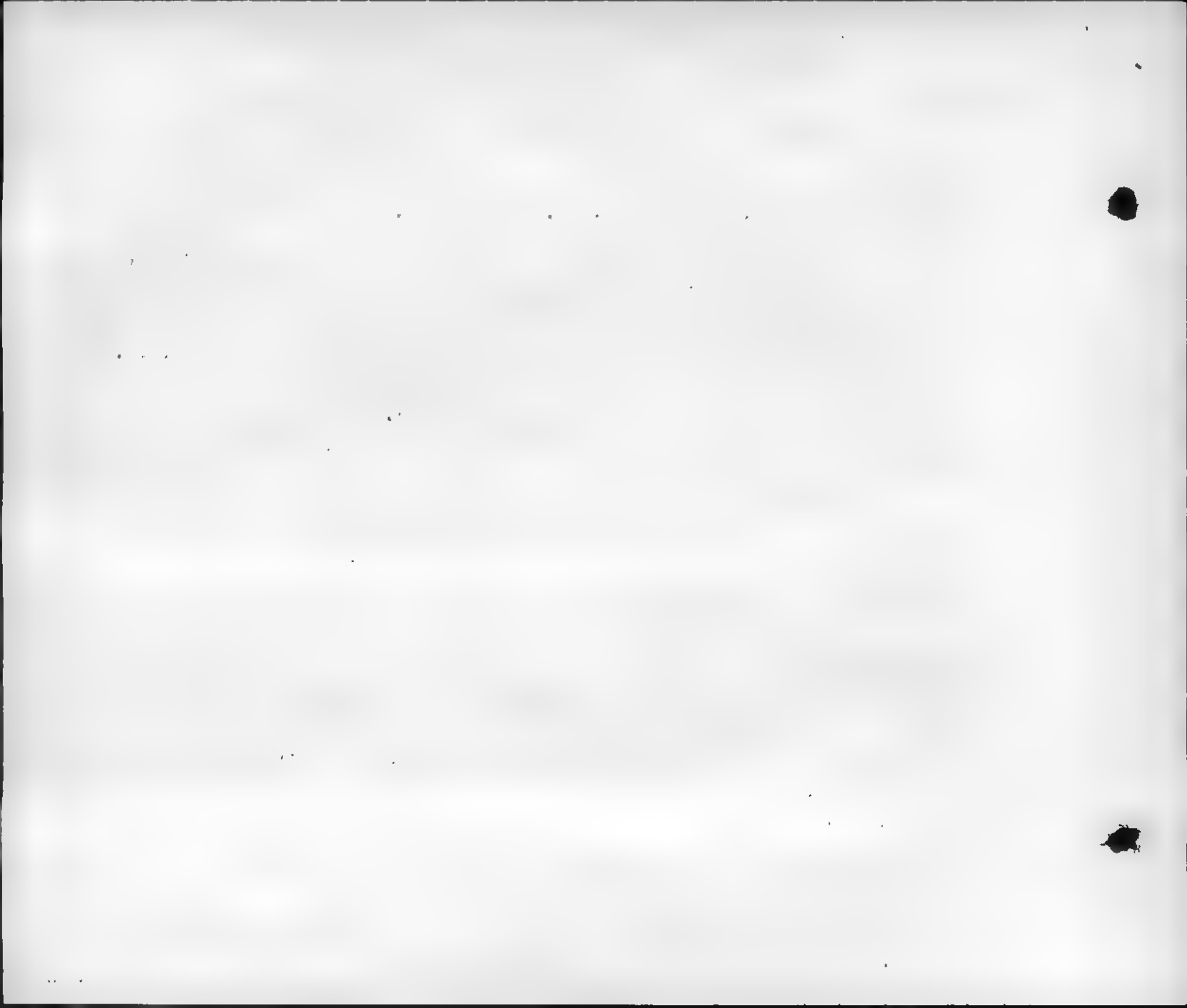
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Arkansas b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 75 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Stamps 4 X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 715 N. Opera Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Mickey Sue Hale			4. DATE OF DEATH Month Day Year September 29, 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 3, 1939		9. AGE (In years last birthday) 18 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Arkansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Paul Cook			14. MOTHER'S MAIDEN NAME Ila Nelle Carroll		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic Shock 648.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Choriocarcinoma Testuans DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVA. BETWEEN ONSET AND DEATH Minutes Months					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1958 , to September 29, 1958 , that I last saw the deceased alive on September 29, 1958 , and that death occurred at 11:00 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 9/29/58 National Institutes of Health Bethesda 14, Maryland					
ACTUAL SIGNATURE JACK LEVIN M.D.					
PHYSICIAN'S NAME (Type) JACK LEVIN, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 10/2/58		22c. NAME OF CEMETERY OR CREMATORY Lake Side Cemetery	
22d. LOCATION (City, town, or county) (State) Stamps, Arkansas					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			24a. REC'D BY REGISTRAR OCT 2 '58		
ADDRESS Bethesda, Maryland			24b. REGISTRAR'S SIGNATURE William S. Knaus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10354

CERTIFICATE OF DEATH

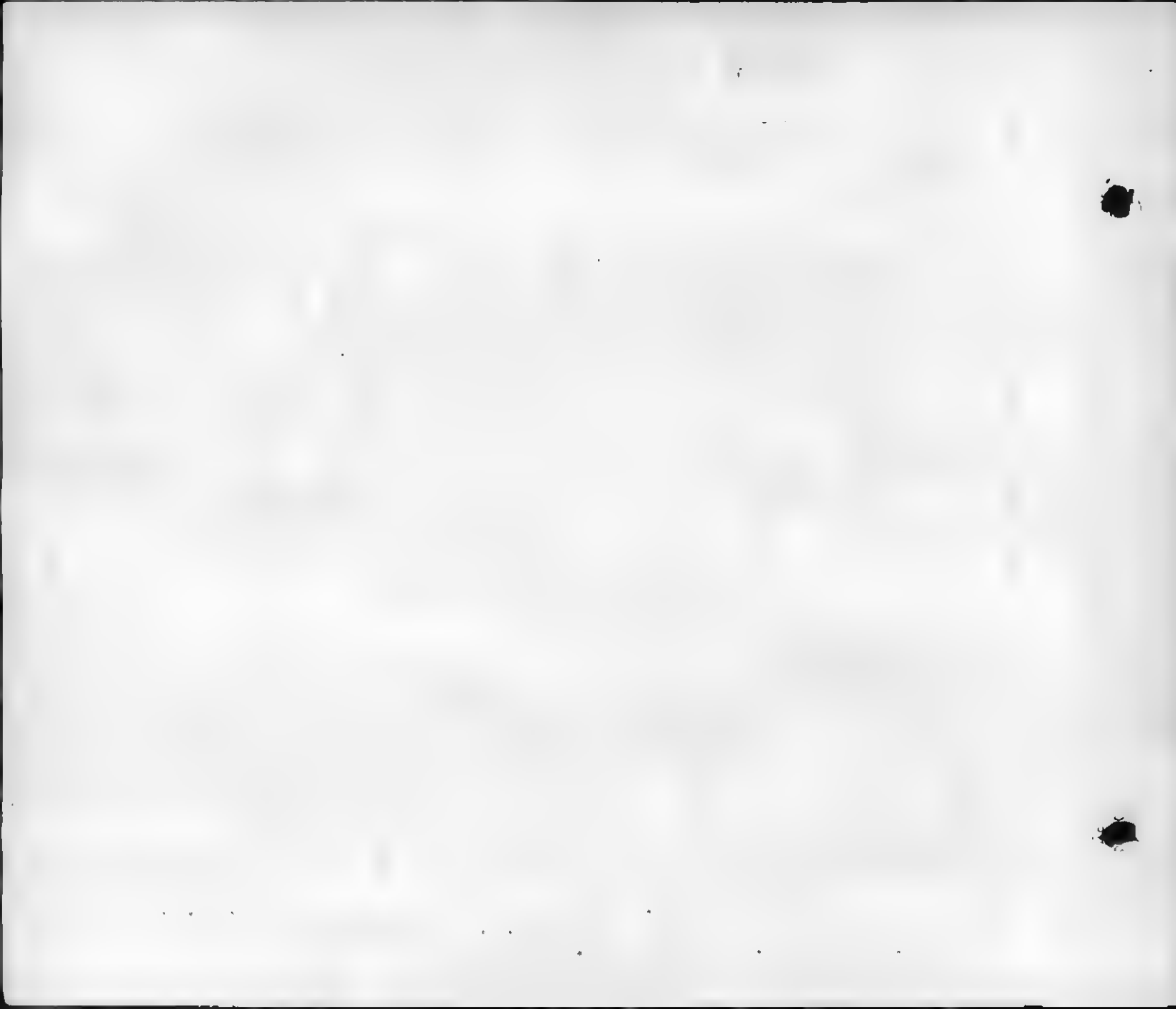
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Springfield</u>	
c. LENGTH OF STAY IN 1b <u>5 Days</u>		d. STREET ADDRESS <u>5507 Chesterbrook Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E.</u> Last <u>Hanson</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Evansville Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles J. Hanson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Charlotta Peterson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Clar. V. Hanson</u>	
17. INFORMANT Address <u>Sage</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLUS</u> <u>527.1</u> DUE TO <u>AURICULAR</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE & FIBRILLATION</u> DUE TO (c) <u>EMPHYSEMA, PULMONARY</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>5 YEARS</u> <u>10 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-12</u> 19 <u>58</u> , to <u>12:40</u> <u>9-10</u> 19 <u>58</u> that I last saw the deceased alive on <u>9-9</u> 19 <u>58</u> , and that death occurred at <u>12:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Philip R. James</u> M.D. <u>WASHINGTON CLINIC, D.C.</u> <u>9-10-58</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>PHILIP R. JAMES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/12/58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wash, D.C.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>The S.H. Hines Co., 2901 14th St. N.W.,</u>		DATE <u>SEP 11 '58</u>	<u>Carroll E. Evans</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10355

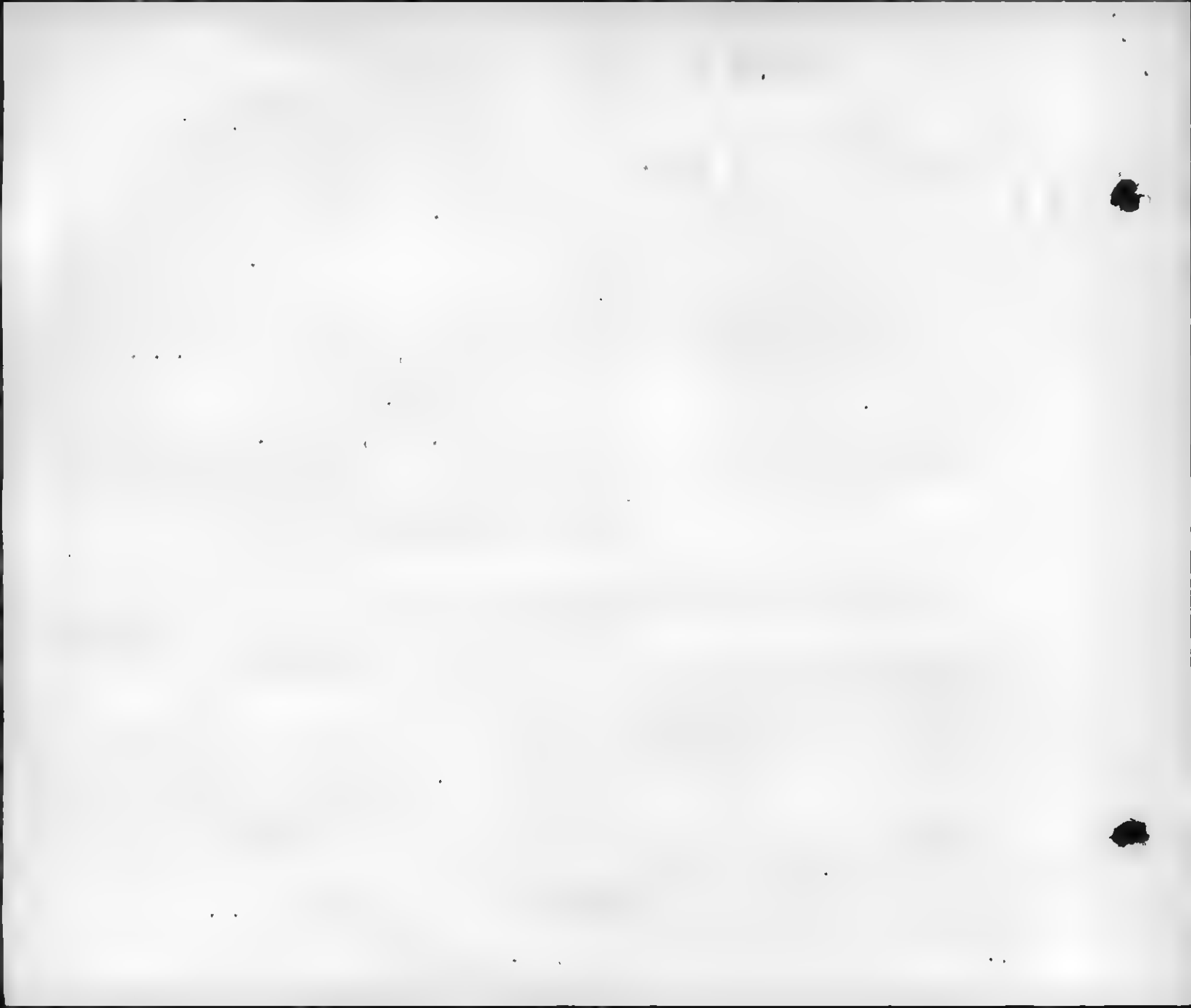
CERTIFICATE OF DEATH

10325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN		c. LENGTH OF STAY IN 1b 1 mo. 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARYLANDER REST HOME				d. STREET ADDRESS 9516 St. Andrews Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSE Middle IRVIN Last HARR				4. DATE OF DEATH Month SEPT. Day 26 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/80		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe salesman self-employed		10b. KIND OF BUSINESS OR INDUSTRY Shoe		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JESSE M. HARR				14. MOTHER'S MAIDEN NAME ANNIE E. WOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Miss Edith M. Harr, 9516 St. Andrews Way Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 482.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 Day 10 days				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 15, 1958 to Sept. 26, 1958 , that I last saw the deceased alive on Sept. 25, 1958 , and that death occurred at 7:40 A.M. from the causes and on the date stated above							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 9/26/58			
PHYSICIAN'S NAME (Type) JAMES P. KERR							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/27/58		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Zucka				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 29 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10280

CERTIFICATE OF DEATH

Reg. Dist. No.

10326

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>59 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7110 Poplar Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>IRENE</u> Last <u>HARRIES</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 28, 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard T. Humphrey</u>				14. MOTHER'S MAIDEN NAME <u>Ada Connors</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u></u>		17. INFORMANT <u>Mr. Martin J. Yates, 629 Dist Ave. S.S.Md.</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Senile arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u> (b) <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr.</u> <u>1946</u> , to <u>3 Sept</u> <u>1958</u> , that I last saw the deceased alive on <u>25 Aug</u> <u>1958</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u> DATE SIGNED <u>3 Sept</u> ACTUAL SIGNATURE <u>H. B. Queen</u> M.D. <u></u> PHYSICIAN'S NAME (Type) <u>H. B. Queen</u> <u>Takoma Park, Md</u> <u>1958</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 5, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Odenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW, D.C.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>SEP 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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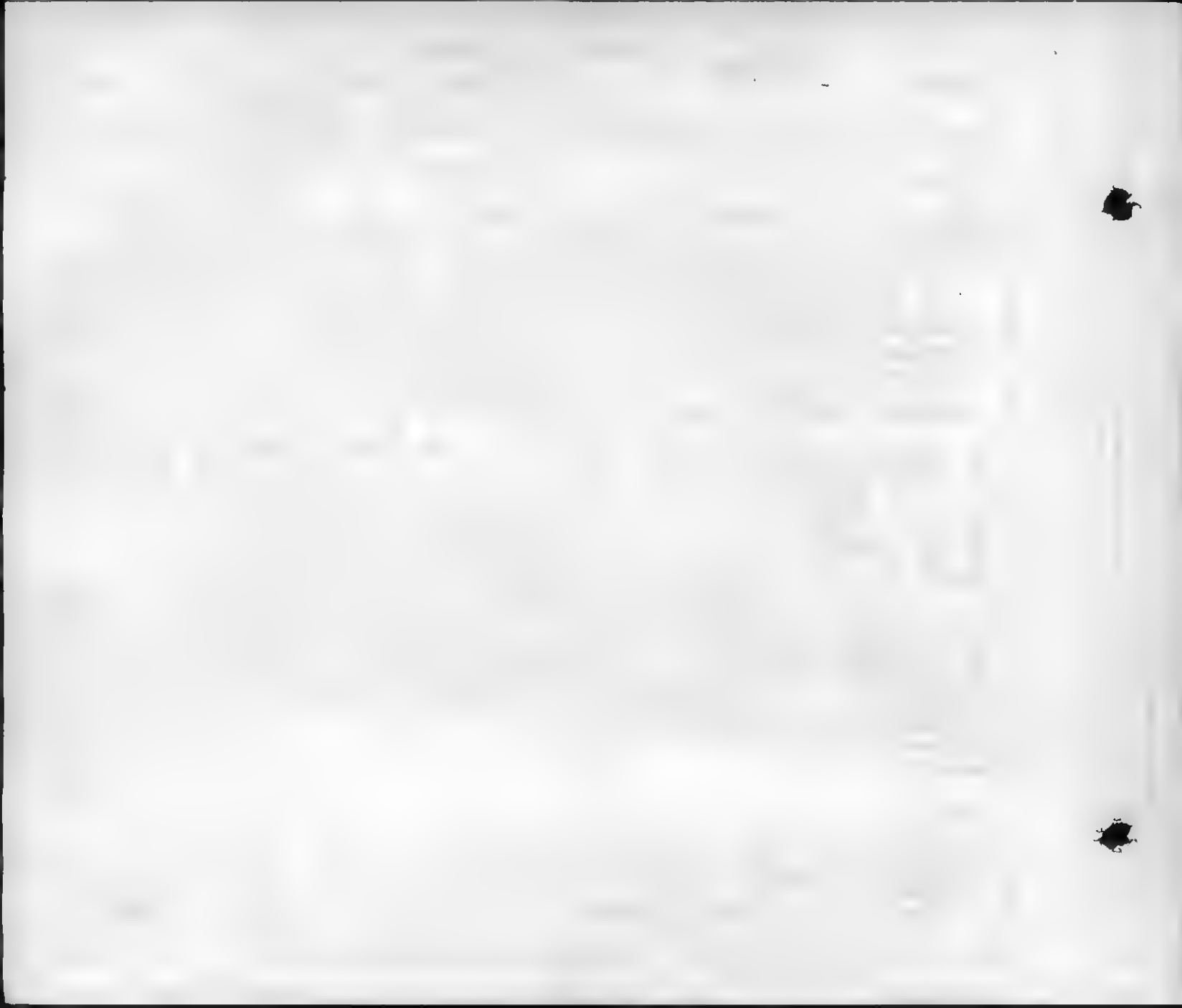
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Item 7, Film G234, 10/9/58 for
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's Hospital, 10411 Hayes Ave.</u>		d. STREET ADDRESS <u>10411 Hayes Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Fay</u> Last <u>Hattery</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 March 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stephen J. Harrison</u>		14. MOTHER'S MAIDEN NAME <u>SARAH A. Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Louise Hattery</u>		Address <u>10411 Hayes Ave, Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vascular occlusion in brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized progressive arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1952</u> to <u>23 Sept 1958</u> , that I last saw the deceased alive on <u>23 Sept 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Martin L. White</u> M.D.		ADDRESS (Street, city or town, state) <u>11134 Georgia Ave Silver Spring, Md 20901</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAND CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>VAN WERT, OHIO</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deane Funeral Home</u>		ADDRESS <u>4812 9th Ave.</u>	
24a. REC'D BY REGISTRAR <u>DET</u>		24b. REG STRAR'S SIGNATURE <u>Arthur S. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10357

CERTIFICATE OF DEATH

Reg. Dist. No.

10328

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2708 FINCH STREET		d. STREET ADDRESS 2708 FINCH STREET	
3. NAME OF DECEASED (Type or print) First MARY Middle THERESA Last HAWKINS		4. DATE OF DEATH Month SEPT. Day 3 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/74
9. AGE (In years last birthday) yrs 84		IF UNDER 1 YEAR Months 2 Days 2	IF UNDER 24 HRS Hours 2 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FREDERICK B. KAUS	
14. MOTHER'S MAIDEN NAME JULIA WHALEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mr. Paul E. Hawkins, 2708 Finch St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION, ARTERIAL DUE TO (c) 20 YRS.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, GENERALIZED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 1957 to 3 SEPT. 1958 , that I last saw the deceased alive on 3 SEPT. 1958 , and that death occurred at 3 P. M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) 9013 FLOWER AVE SILVER SPRING, MD. DATE SIGNED 9/4/58	
ACTUAL SIGNATURE LBSnow		PHYSICIAN'S NAME (Type) L. B. SNOW	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/5/58	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

10329

Reg. Dist. No.

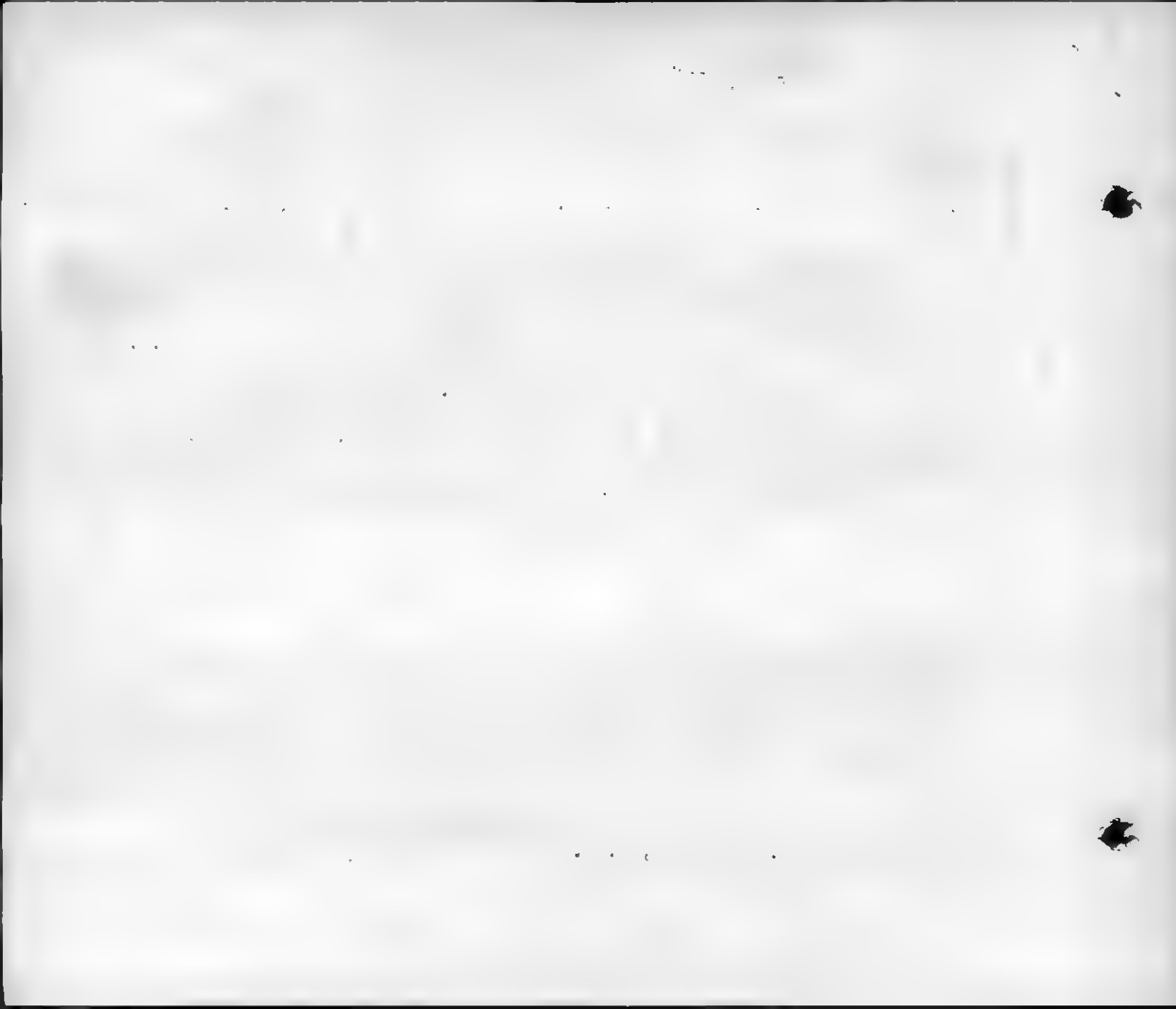
10358

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4001 8th Street, S.E.			
3. NAME OF DECEASED (Type or print) First Gerald Middle Jameson Last Hayden				4. DATE OF DEATH Month September Day 14 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 December 1942	9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leo Hayden				14. MOTHER'S MAIDEN NAME Mary V. Jameson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Pulmonary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b). Widespread pulmonary metastases 2 mos. (c). Rhabdomyosarcoma, Rt chest wall 9 mos. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH 3 wks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from August 23, 1958 , to September 14, 1958 , that I last saw the deceased alive on September 14, 1958 , and that death occurred at 10:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/15/58							
ACTUAL SIGNATURE Harold R. Silberman, M.D.				PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-17-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		22d. LOCATION (City, town or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers, Inc.				24a. REC'D BY REGISTRAR SEP 17 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



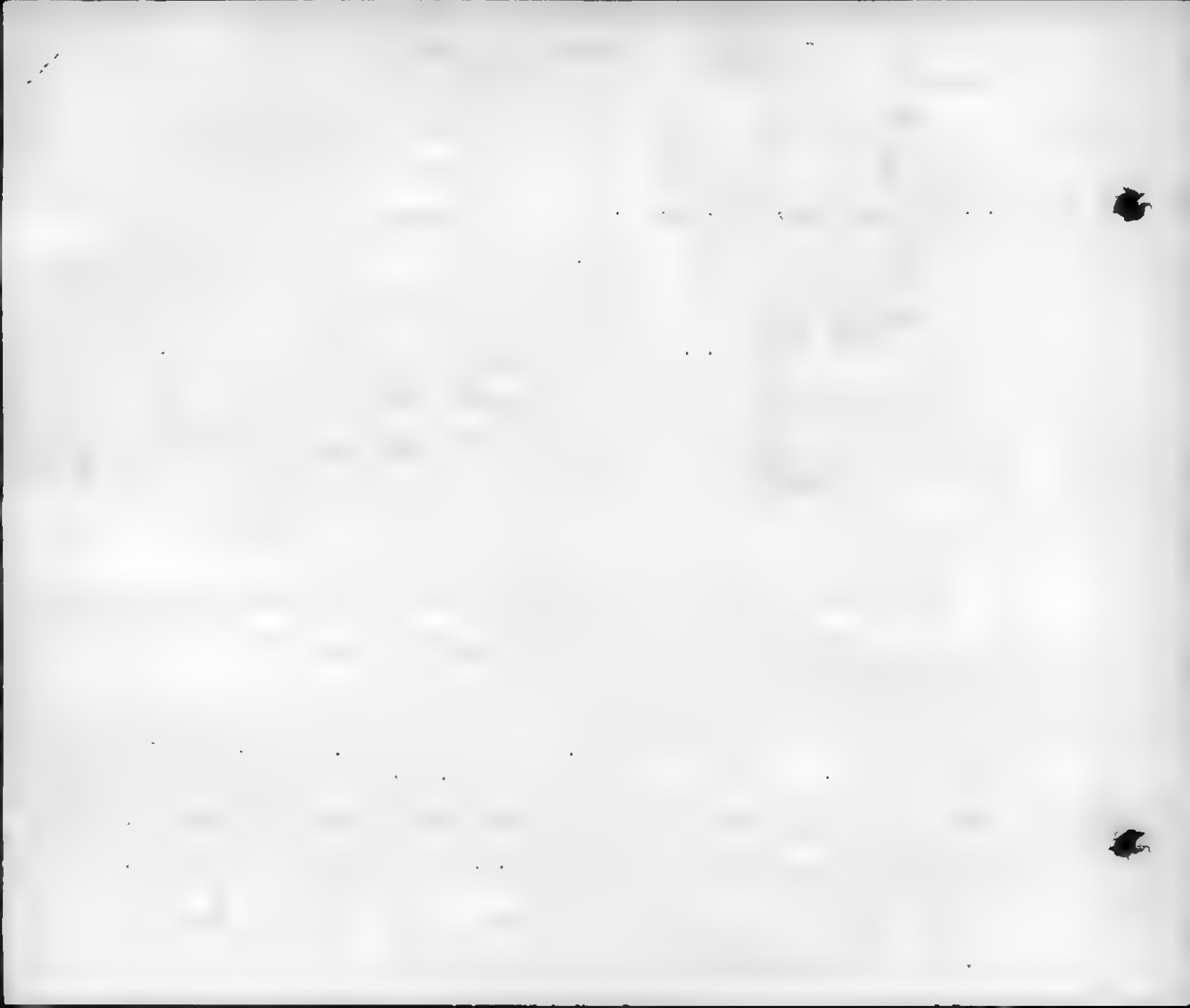
10359

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Georgia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charlie Morriel HEAD				4. DATE OF DEATH Month Day Year September 14 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 October 1937	
9. AGE (In years last birthday) yrs 20		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Charlie Manuel HEAD				14. MOTHER'S MAIDEN NAME Ophelia STAPP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes, Currently				16. SOCIAL SECURITY NO. 254 50 5034		17. INFORMANT (Wife) Mrs. Sharon Lucille HEAD (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, diffuse 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) primary site unknown DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 WKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Covington				20g. (County) Georgia		20h. (State) Georgia	
21. I certify that I attended the deceased from 9 Sept. , 19 58 , to 14 Sept. , 19 58 , that I last saw the deceased alive on 14 Sept. , 19 58 , and that death occurred at 3:05 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Galbraith Jr.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
DATE SIGNED 9-15-58							
PHYSICIAN'S NAME (Type) Robert G. Galbraith, Jr. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-58		22c. NAME OF CEMETERY OR CREMATORY Lawnwood Cemetery		22d. LOCATION (City, town, or county) (State) Covington, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 1400 Chapin St. Washington, D.C.				24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE William L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

10360

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5525 Prospect Street</u>				e. STREET ADDRESS <u>5525 Prospect Street</u>			
3. NAME OF DECEASED (Type or print) First <u>EVELYN</u> Middle <u>A.</u> Last <u>HEARN</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/1880</u>	9. AGE (In years last birthday) <u>78</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>2</u> Days <u>20</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Archie H Asquith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rutherford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wilfred Hearn-husband-same as item #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>1949, to 9-10, 1958</u> , that I last saw the deceased alive on <u>9-9, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1150 Conn. Ave. NW Wash D.C.</u> DATE SIGNED <u>9/10/58</u>							
ACTUAL SIGNATURE <u>Andrew G. Preindoni</u> M.D.		ADDRESS (Street, city or town, state) <u>1150 Conn. Ave. N.W. Wash. D.C.</u>					
PHYSICIAN'S NAME (Type) <u>Andrew G. Preindoni</u>		ADDRESS <u>1150 Conn. Ave. N.W. Wash. D.C.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edgemoor Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Charlestown, Virginia</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>			24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

10332

10361

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 131 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Harry Last Hilgeman		4. DATE OF DEATH Month September Day 21 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Chief		10b. KIND OF BUSINESS OR INDUSTRY Fire fighting	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick G. Hilgeman		14. MOTHER'S MAIDEN NAME Mary Huiss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 212-28-8222	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUB-DURAL HEMORRHAGE, P.L.H. IDENT. DUE TO CARCINOMA OF MAXILLARY ANTRUM & LOCAL EXTENSION TO SKULL, & GENERALIZED METASTASES. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13, 1958 , to September 21, 1958 , that I last saw the deceased alive on September 21, 1958 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/22/58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
ACTUAL SIGNATURE Marvin Romsdahl M.D.			
FURNITURE NAME (Type) Marvin Romsdahl, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/25/58	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Balto, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE SEP 25 '58	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10333

Reg. Dist. No.

10362

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>865 Heron Drive</u>		d. STREET ADDRESS <u>1805 Heron Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Charles F. Hoffman Jr</u>		4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY YARD</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES F. HOFFMAN SR</u>		14. MOTHER'S MAIDEN NAME <u>LAURA STEWART</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DOROTHY YLUNG</u>		Address <u>805 HERON DR SIL SPRG MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>104.00 x.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsons Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>15 July</u> , 1958, to <u>10 Sept</u> , 1958, that I last saw the deceased alive on <u>9 Sept</u> , 1958, and that death occurred at <u>9:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. B. Queen</u> M.D.		ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u> DATE SIGNED <u>10 Sept 1958</u>	
PHYSICIAN'S NAME (Type) <u>A. B. QUEEN</u>		Address <u>Takoma Park, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCKVILLE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ROCKVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO</u> ADDRESS <u>1480 CHAPIN ST</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



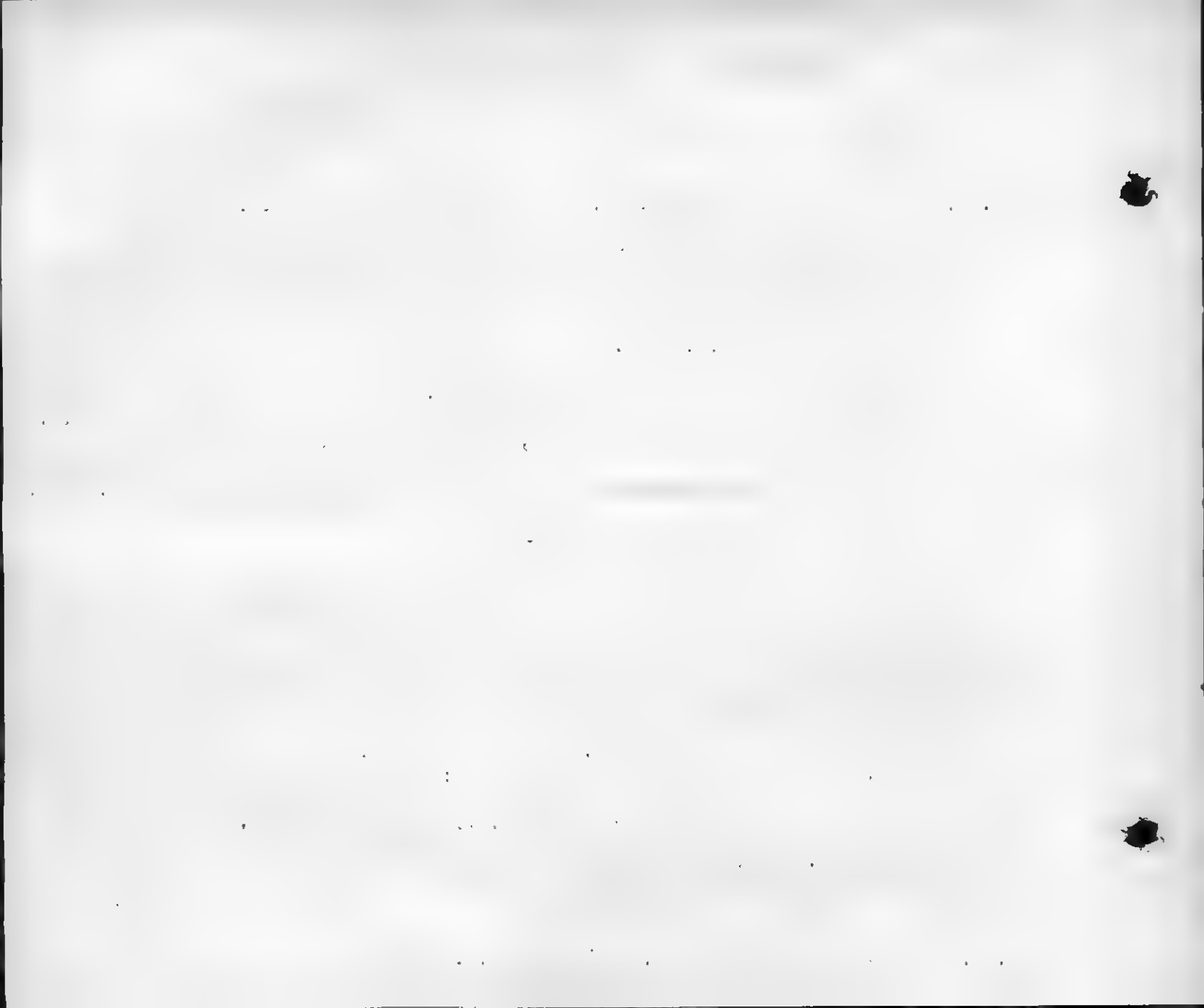
10363
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 1363 Euclid Street, N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Waymond Everett HOLLAND		4. DATE OF DEATH Month Day Year September 26 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-97
9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William HOLLAND		14. MOTHER'S MAIDEN NAME Dora M. STORLTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 577-09-9036	
17. INFORMANT Wife, Gertrude Holland, 1306 Euclid St., NW		Address: Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic carcinoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 mo. appr. unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 1 , 19 58 , to Sept. 26 , 19 58 , that I last saw the deceased alive on Sept. 25 , 19 58 , and that death occurred at 6:40 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 9-27-58			
ACTUAL SIGNATURE Jerome A. Gold M.D.		PHYSICIAN'S NAME (Type) Jerome A. Gold, LT, MC, USN Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-3-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis, 1432 U Street, N.W., Washington, D.C.		24a. REC'D BY REGISTRAR SEP 30 1958	24b. REGISTRAR'S SIGNATURE Charles S. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10281

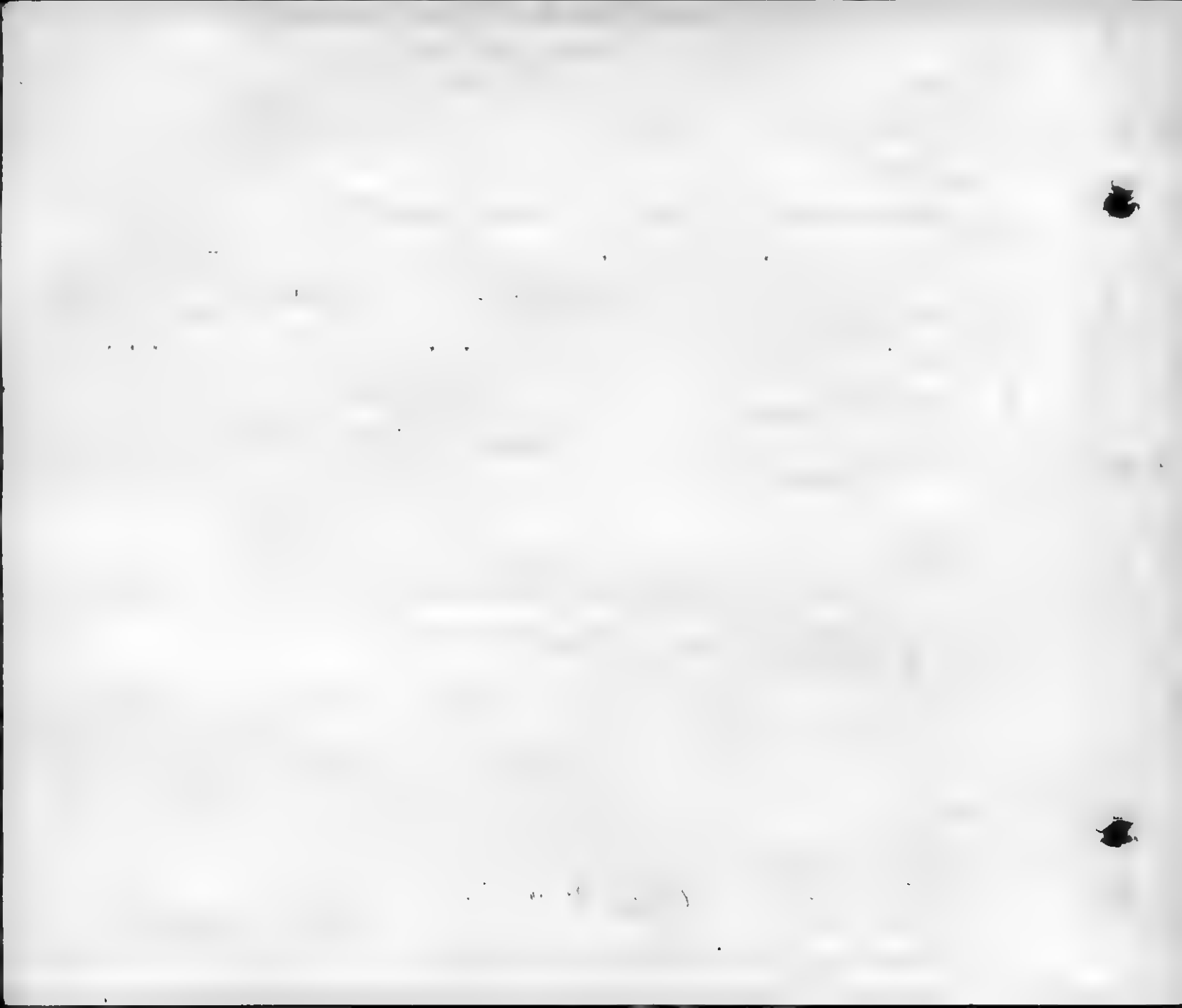
CERTIFICATE OF DEATH

10335

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY F.P.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 67 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Sanitarium & Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. STREET ADDRESS 16 Canary Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First L. Middle A. Last Horton				4. DATE OF DEATH Month 9 - Day 17 - Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-'93	9. AGE (In years lay b. rthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrument Maker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Y.	
13. FATHER'S NAME George Horton				14. MOTHER'S MAIDEN NAME Martha Duvall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Washington Sanitarium & Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Left Cerebellar Hemorrhage DUE TO Left Subarachnoid Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hypertension & Atherosclerosis DUE TO Hypertension & Atherosclerosis DUE TO Hypertension & Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3-4 hours 3-4 hours 1 1/2 hours			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Heart Failure, Subacute Bacterial Endocarditis, Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Dec 14, 1955 to Sept 17, 1958 , that I last saw the deceased alive on Sept. 16, 1958 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Russell B. Arnold M.D.				ADDRESS (Street, city or town, state) 8801 Colverville Road			
PHYSICIAN'S NAME (Type) Russell B. Arnold M.D.				DATE SIGNED Sept 19 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 19-1958		22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Falls Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters				ADDRESS 254 Carroll St NW DC		24a. REC'D BY REGISTRAR SEP 19 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris							

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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

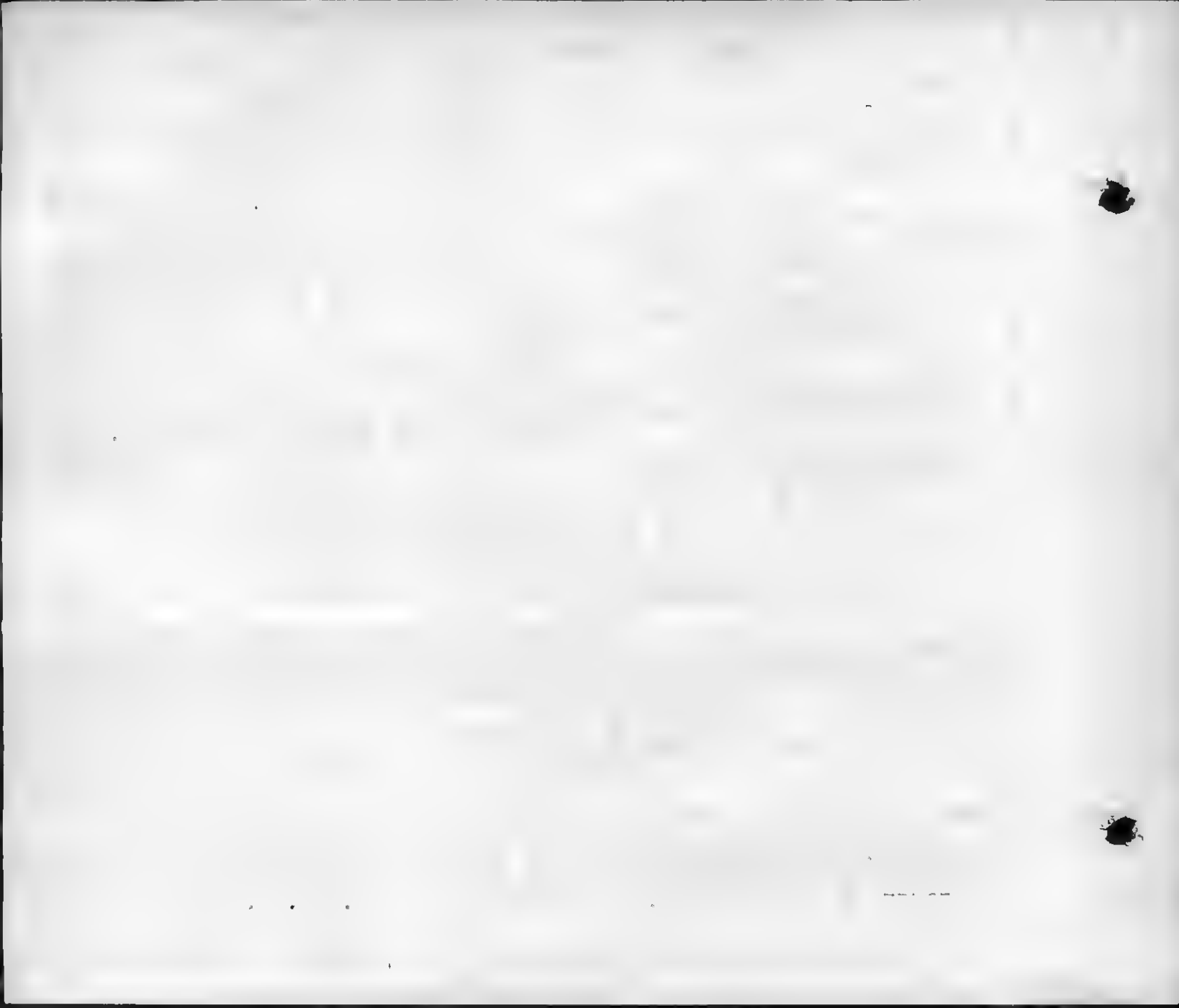
10364

CERTIFICATE OF DEATH

Reg. Dist. No.

10336

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 2963 Tilden Street, N.W.			
3. NAME OF DECEASED (Type or print) First William Middle R Last Houchen				4. DATE OF DEATH Month September Day 5 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 8, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN LEWIS HOUCHEN				14. MOTHER'S MAIDEN NAME AMANDA TANNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mary Rose Houchen, 2963 Tilden St. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-25 , 19 58 , to 9-5 , 19 58 , that I last saw the deceased alive on 9-5 , 19 58 , and that death occurred at 11:05 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. Fleet Luckett				ADDRESS (Street, city or town, state) 5000 Kansas Rd N.W. DATE SIGNED 9-6-58			
PHYSICIAN'S NAME (Type) Wm. Fleet Luckett							
22a. BURIAL CREMATION, CREMATION cremation		22b. DATE THEREOF 9/8/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Thomas Co.				ADDRESS 2901-14 ST. N.W. D.C.		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
				24b. REGISTRAR'S SIGNATURE Charles S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10365

CERTIFICATE OF DEATH

Reg. Dist. No.

10337

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Colonial Beach</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colonial Beach</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Mellie</u> Middle <u>T.</u> Last <u>Hoy</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt worker</u>		11. BIRTHPLACE (State or foreign country) <u>Silver Sp - Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Patrick Ryan</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Devaney</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>(If yes, give year or dates of service)</u>				17. INFORMANT <u>Mrs Donald Watson</u> Address <u>9917 Edgewood Rd Bethesda - Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>592v</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis -</u> (c) <u>Chronic Nephritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>99. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. s.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Dec 1, 1956</u> to <u>Sept 10, 1958</u> , that I last saw the deceased alive on <u>9/11</u> <u>1958</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>[Address]</u>			
PHYSICIAN'S NAME (Type) <u>Dr. J. W. Bird</u>				DATE SIGNED <u>9/10/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nancy Collins</u>				ADDRESS <u>3821-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				DATE <u>SEP 15 '58</u>		24c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



10282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>De</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>708 Philadelphia Ave</u>		d. STREET ADDRESS <u>867-10 St. N.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>EMILY</u> Middle <u>B.</u> Last <u>HUGHES</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 20, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>yes</u>		13. FATHER'S NAME <u>ARCHIBALD BURGESS</u>	
14. MOTHER'S MAIDEN NAME <u>SARAH F. TURPIN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Catherine A. Frank - 1300 Key Bldg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Decomposition</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hyponatremia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Cerebral</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> to <u>1958</u> , that I last saw the deceased alive on <u>5 Sept</u> 195 <u>7</u> , and that death occurred at <u>5:50 A</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>William G. Lind</u> M.D.		ADDRESS (Street, city or town, state) <u>9016 W. Capitol Rd</u>	
PHYSICIAN'S NAME (Type) <u>William G. Lind</u>		DATE SIGNED <u>9/16/58</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-9-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Levens</u>		ADDRESS <u>WASH. D.C.</u>	
24a. REC'D BY REGISTRAR <u>SEP 8 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Jan 23
JH

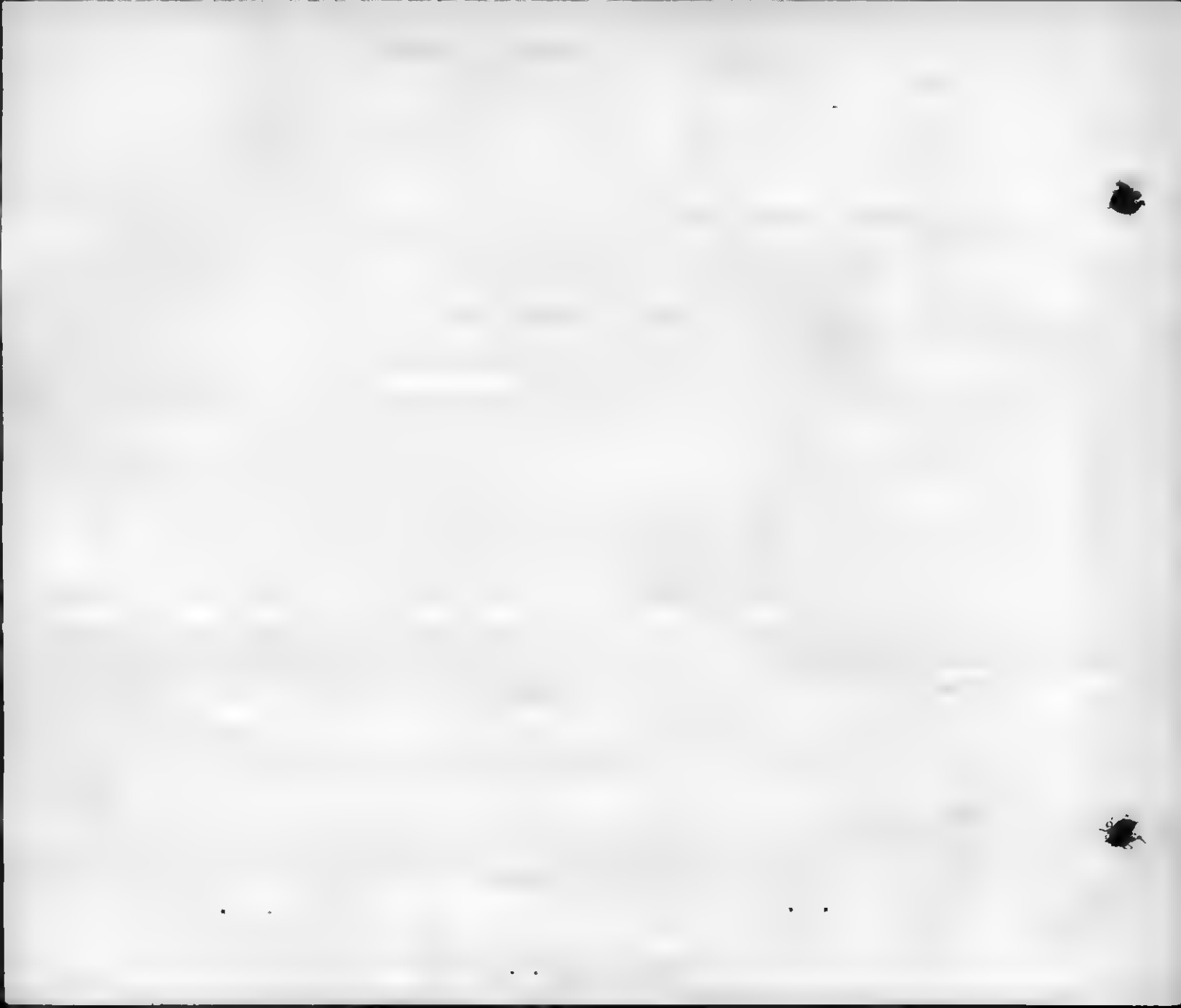
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10366

CERTIFICATE OF DEATH

Reg. Dist. No. 10339

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1918-18th St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Hughes</u> Last <u>Hughes</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22 1890</u> yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Lottie Bealer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Angerline Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>10 years.</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/3</u> , 19 <u>58</u> , to <u>9/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/7</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1835 Eye St N.W.</u> DATE SIGNED <u>9/8/58</u>							
ACTUAL SIGNATURE <u>Alvin E. Kay</u> M.D.				PHYSICIAN'S NAME (Type) <u>ALVIN E. KAY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9.10.58</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Lexington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman</u> ADDRESS <u>1840-9</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
				DATE <u>SEP 10 58</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

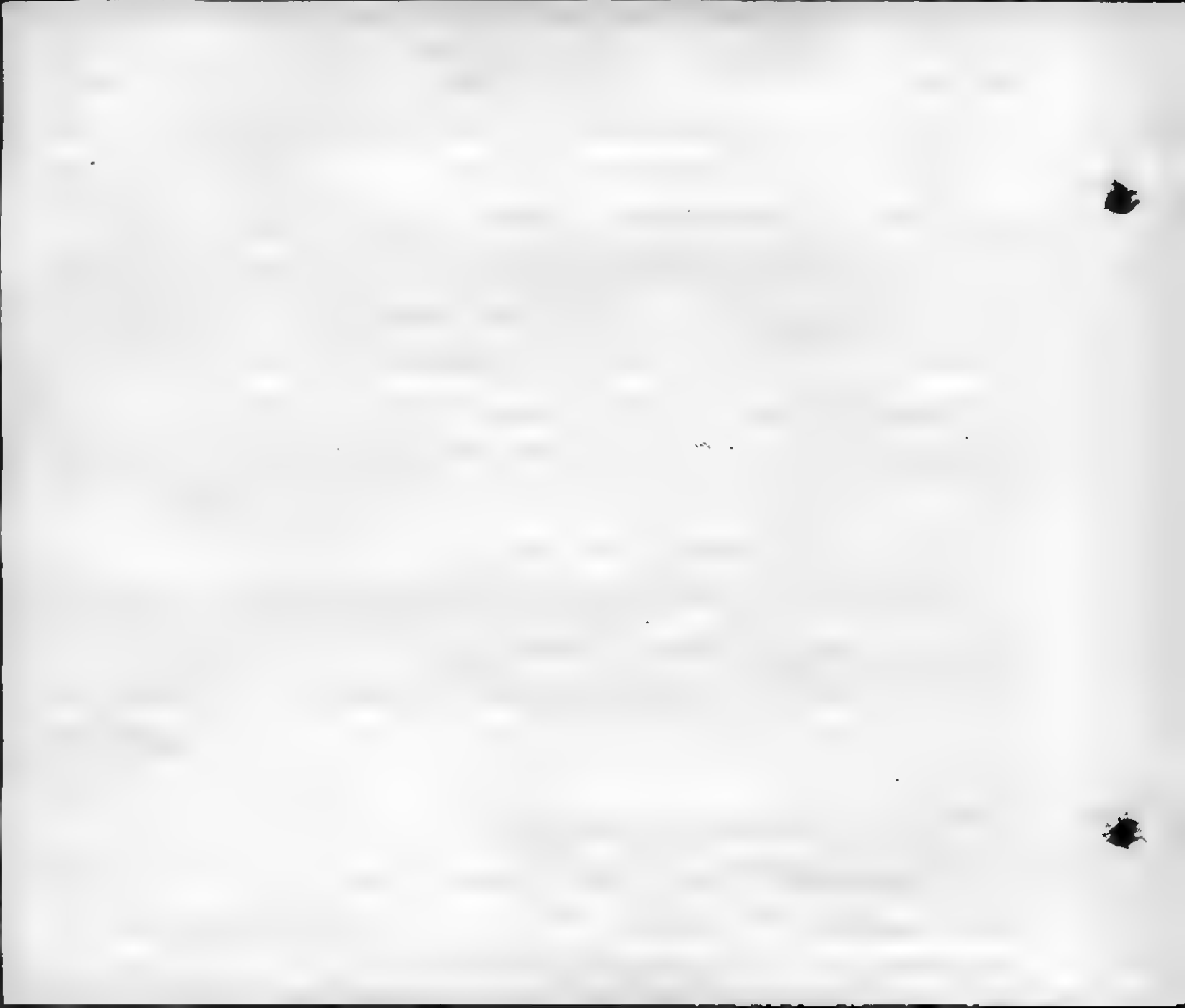
10367

CERTIFICATE OF DEATH

Reg. Dist. No.

10340

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burnsville</u>			
c. LENGTH OF STAY IN 1b <u>15 days</u>				d. STREET ADDRESS <u>51. Mary' Rectory</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>William</u> Last <u>Hyland</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30 1888</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mid Racing Assoc</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Martin W. Hyland</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Burns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-07-9458</u>		17. INFORMANT Address <u>Martin W. Hyland, Burnsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>Bronchopneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 month</u> <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 11</u> , 19 <u>58</u> , to <u>Sept 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 7</u> , 19 <u>58</u> , and that death occurred at <u>9:24 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>DAWSONVILLE</u> DATE SIGNED <u>7 Sept. 58</u>							
ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D.			SIGNATURE <u>DAWSONVILLE</u>				
PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT</u>			ADDRESS <u>P.O. Box 4 D, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fate of Home</u>		22d. LOCATION (City, town, or county) (State) <u>Galena, Schuylkill Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Wilson</u> ADDRESS <u>Burnsville, Md.</u>			24a. REC'D BY REGISTRAR <u>SEP 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		



10341

10368

CERTIFICATE OF DEATH

Reg. Dist. No. 215

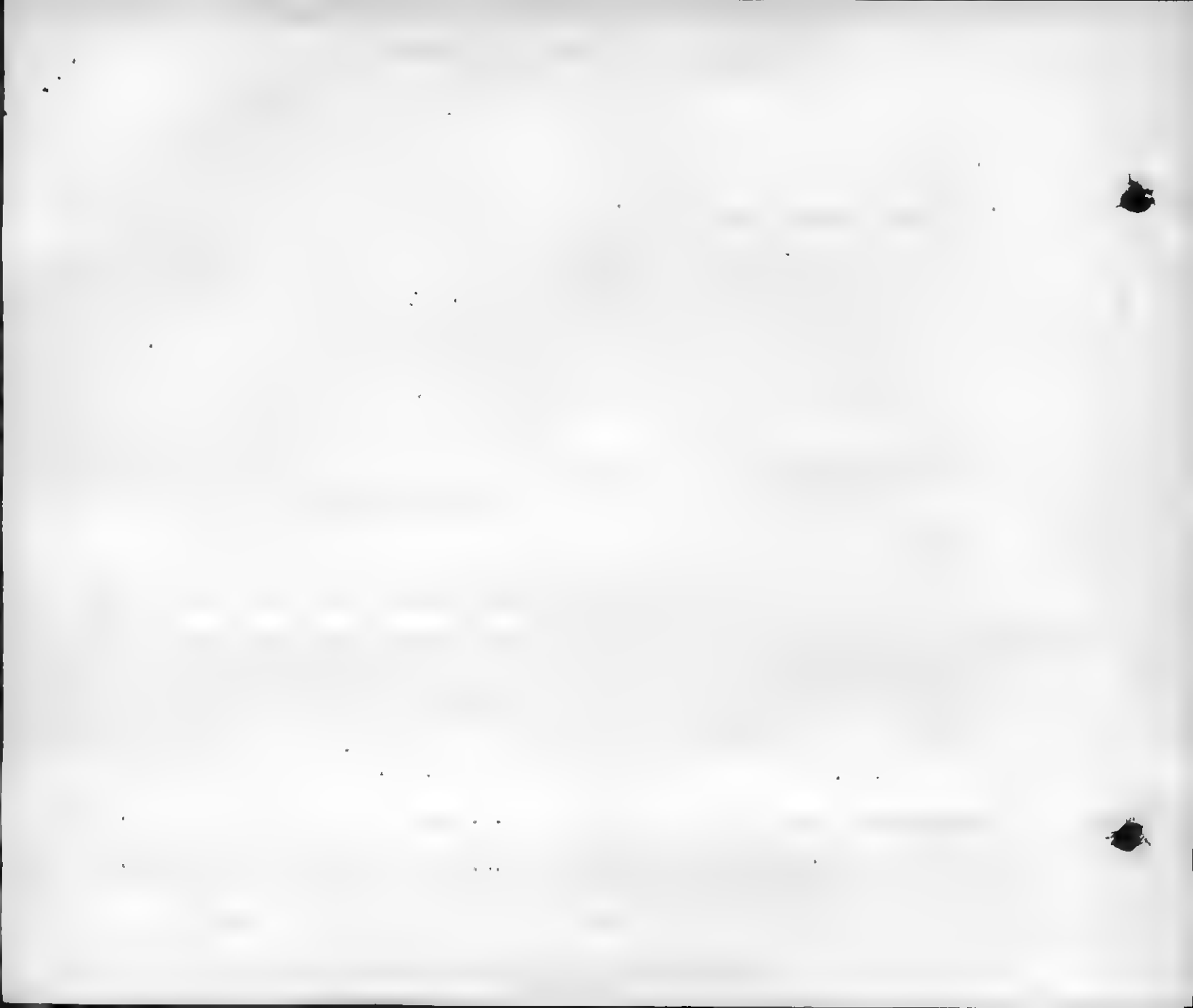
1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 340 Midway Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gregory Paul Johnson				4. DATE OF DEATH Month Day Year September 5 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Sept. 1958	
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months Days Hours Min 2		IF UNDER 24 HRS. Months Days Hours Min 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Herbert JOHNSON				14. MOTHER'S MAIDEN NAME Frances D. DRAKE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Herbert Johnson (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline membrane disease 713.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF DEATH Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Sept , 19 58 , to 5 Sept. , 19 58 , that I last saw the deceased alive on 5 Sept. , 19 58 , and that death occurred at 3:15A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-5-58							
ACTUAL SIGNATURE Howard A. Pearson		PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-58		22c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery		22d. LOCATION (City, town, or county) (State) Leonardtown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Mattingly Funeral Home, Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE SEP 9 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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10369

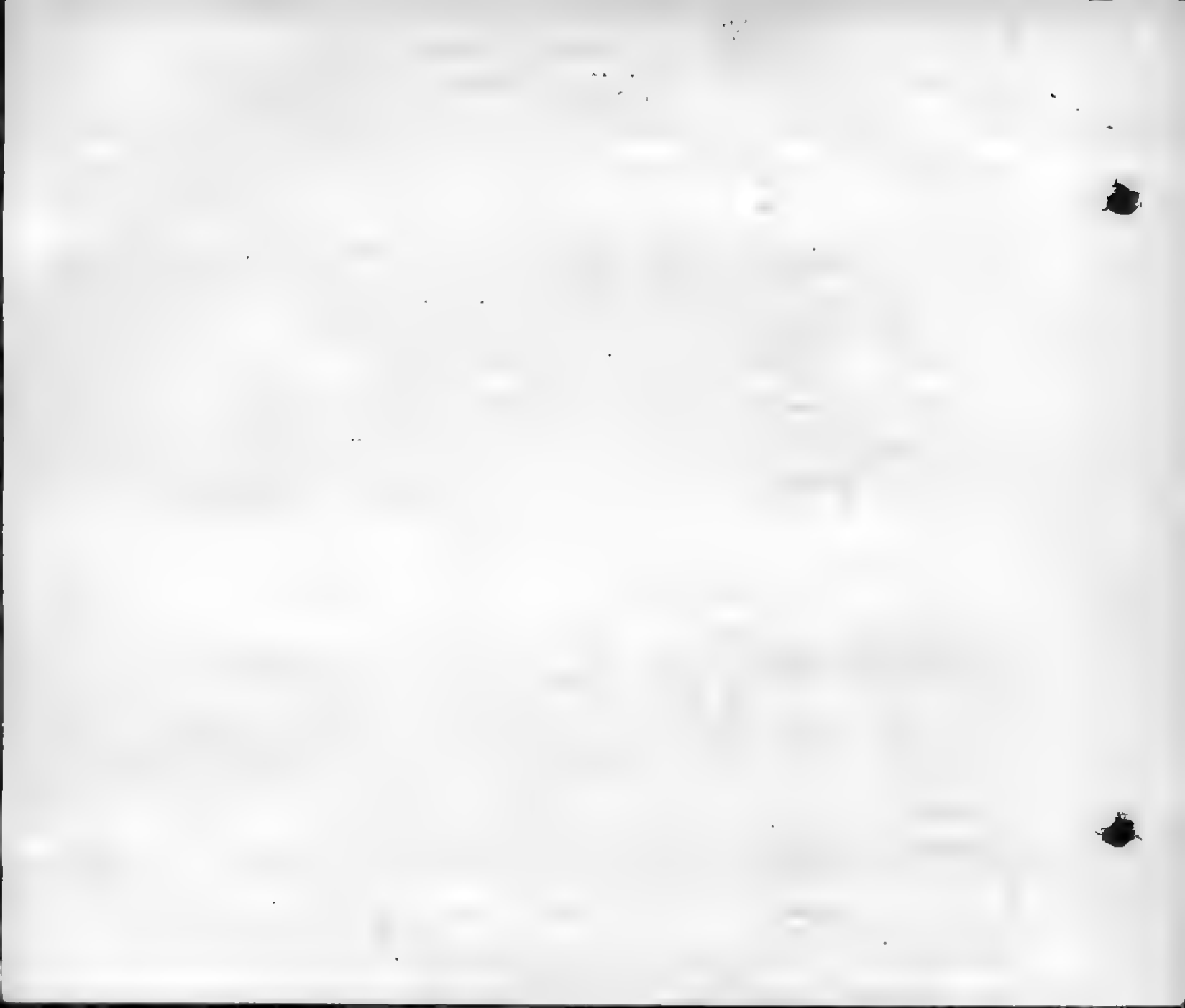
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3517 Randolph Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLIE</u> Middle <u>JONES</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1871</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>8</u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles J. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mary E Trunnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Carroll V Jones-son-same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacteremia</u> <u>602X</u> DUE TO <u>Retro Renal Abscess - Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Belateral Stalled Renal Calculi</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks - 2 years - 15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 1955</u> to <u>27 Sept 1958</u> , that I last saw the deceased alive on <u>27 Sept 1958</u> , and that death occurred at <u>11:56 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Murphy</u>				DATE SIGNED <u>6-15-58</u>			
PHYSICIAN'S NAME (Type) <u>William S. Murphy</u>				<u>615 W. Monte. Ave. Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Rumhrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 30 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Murphy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10283

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>DOA.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. STREET ADDRESS <u>7711 Greenwood Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Amelia Anna Kidd</u>				4. DATE OF DEATH <u>Sept. 28 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-14-90</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kitchen helper-</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William H. Hood</u>				14. MOTHER'S MAIDEN NAME <u>Emma Hunt Hood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cronary insufficiency</u> DUE TO <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized.</u> (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>October 1957</u> , to <u>September 19, 1958</u> , that I last saw the deceased alive on <u>September 28, 1958</u> , and that death occurred at <u>7:40 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D. <u>8837 Georgia Ave. Silver Spring Md. Sept 29 1958.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 3, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BLAINE, OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. J. Staley</u> ADDRESS <u>254 Carroll St NW, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>A. J. Staley</u>	

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10370

CERTIFICATE OF DEATH

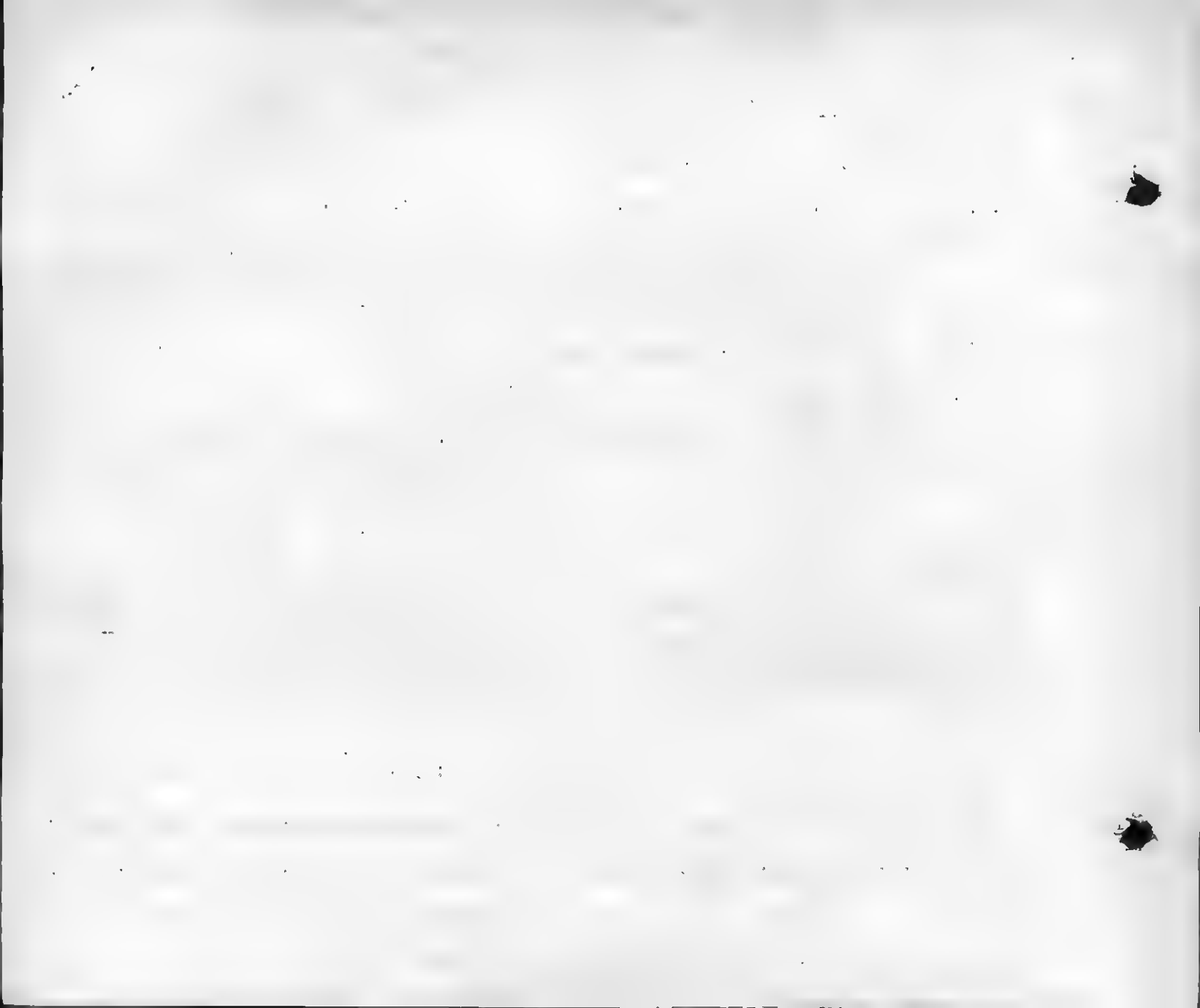
10344

Reg. Dist. No. 25

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN 1b <u>20 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>312 3rd Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Russell</u> Last <u>KINSMAN</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 February 1895</u>		9. AGE (In years last birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Marine Corps</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>William Henry KINSMAN</u>				14. MOTHER'S MAIDEN NAME <u>Greta ISACSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I&II 225 20 8043</u>		17. INFORMANT Address <u>(Wife) Mrs. Amie Harper KINSMAN (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>THROMBOSIS, CEREBRAL VESSELS, MULTIPLE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS OF CEREBRAL VESSELS</u> DUE TO (c) <u>7 YEARS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION, SEVERE, ESSENTIAL</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 August</u> , 19 <u>58</u> , to <u>8 Sept.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8 Sept.</u> , 19 <u>58</u> , and that death occurred at <u>7:45 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. S. Caldwell</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. U.S. Naval Hospital, NNMC, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>F.S. CALDWELL, LT, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md. 9-8-58</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hall Funeral Home, Occoquan, Virginia</u>				24a. REC'D BY REGISTRAR <u>SEP 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carla S. King</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10371

CERTIFICATE OF DEATH

10345

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admittance) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN TB 5 mos. 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
3. NAME OF DECEASED (Type or print) First William Middle (nmn) Last KLAUS		4. DATE OF DEATH Month September Day 13 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 November 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William John KLAUS		14. MOTHER'S MAIDEN NAME (First Name Unknown) HAGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW-I&II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Wife) Mrs. Arda P. KLAUS (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY OBSTRUCTION DOX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA OF LUNGS DUE TO (c) SQUAMOUS CELL CARCINOMA ESOPHAGUS		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 1 YEAR 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of stem 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 April 19 58 , to 13 Sept. 19 58 , that I last saw the deceased alive on 13 September 19 58 , and that death occurred at 4:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George W. Taylor, Jr. M.D. U.S. Naval Hospital, Bethesda, Md. 9-13-58			
ACTUAL SIGNATURE George W. Taylor, Jr. M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) George W. Taylor, Jr. CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-17-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Dumbrey		ADDRESS 1557 Wisconsin Ave. Bethesda, Md.	
24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10346

10372

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Woods, Rockville</u>	
c. LENGTH OF STAY IN 1b <u>1 hour</u>		d. STREET ADDRESS <u>13004 Parkland Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fred Edward Kotz</u>		4. DATE OF DEATH Month Day Year <u>Sept. 4 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min <u>52</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxicab Owner-Operator</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>James Edward Kotz</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Miley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Mrs. Regina Kotz</u>		Address <u>13004 Parkland Drive</u> <u>Wheaton Woods, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wardensville</u>		22d. LOCATION (City, town, or county) (State) <u>West Virginia.</u>	
23. GENERAL DIRECTOR'S SIGNATURE <u>J. W. Lee Sons</u>		ADDRESS <u>Wash. D. C.</u>	
24a. REC'D BY REGISTRAR <u>SEP 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 18 Film 235 11-12-53 185

10284

Reg. Dist. No. 1347

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Res'd. before admission) b. COUNTY <u>Montg. Co</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DCR</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>			d. STREET ADDRESS <u>1307 Spring Ave</u>		
3. NAME OF DECEASED (Type or print) First <u>Vincent</u> Middle <u>James</u> Last <u>Lanza</u>			4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-58</u>		9. AGE (In years last birthday) <u>—</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
13. FATHER'S NAME <u>Vincent James Lanza Jr.</u>			14. MOTHER'S MAIDEN NAME <u>Peterson Murphy</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records - 7600 Carroll Ave Tak.Pk.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interstitial pneumonia</u>					
<u>525X</u> DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u>					
(c) <u>—</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>9-18-58</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 22, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u>		ADDRESS <u>254 Carroll St NW DC</u>		24a. REC'D BY REGISTRAR <u>SEP 22 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

©



CERTIFICATE OF DEATH

Reg. Dist. No. 10348

10285

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Montgomery</u> MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>		d. STREET ADDRESS <u>710 Wabash Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>—</u> Last <u>Lawrence</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-77</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Scott Woodring</u>		14. MOTHER'S MAIDEN NAME <u>Nancy McMullen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>old hosp. record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>30 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 26</u> , 19 <u>58</u> , to <u>Sept 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>58</u> , and that death occurred at <u>10:14 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>Takoma Park</u> DATE SIGNED <u>9/26/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)
<u>Burial</u>	<u>Sept 29, 1958</u>	<u>GEORGE WASHINGTON</u>	<u>Riggs Rd., Hyattsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Hare</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '58</u>	
ADDRESS <u>254 Carroll St. NW, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10373

CERTIFICATE OF DEATH

10349

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN b. <u>11 days</u>		d. STREET ADDRESS <u>1003 Paul Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora Jane Learmonth</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1882</u>
9. AGE (In years last birthday) <u>76</u> yn.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTH PLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert McClure</u>		14. MOTHER'S MAIDEN NAME <u>Nora Mead</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Robert Learmonth</u>		Address <u>1003 Paul Dr. Rockville, MD</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>DIABETES Mellitus</u> DUE TO (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u> <u>2 1/2 HRS</u> <u>20 YEARS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 50</u> to <u>2/Sept 1958</u> , that I last saw the deceased alive on <u>19 Sept 1958</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Gordon Rosenberger</u> M.D.		<u>26 N. Summit Dr. 5/15/58</u>	
PHYSICIAN'S NAME (Type) <u>GORDON ROSENBERGER</u>		<u>1400 N. 4th St. 1/15/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>REMOVAL</u>	<u>9/26/58</u>	<u>PERU CITY CEMETERY</u>	<u>PERU, ILLINOIS</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zucka</u>		ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>C. L. King</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

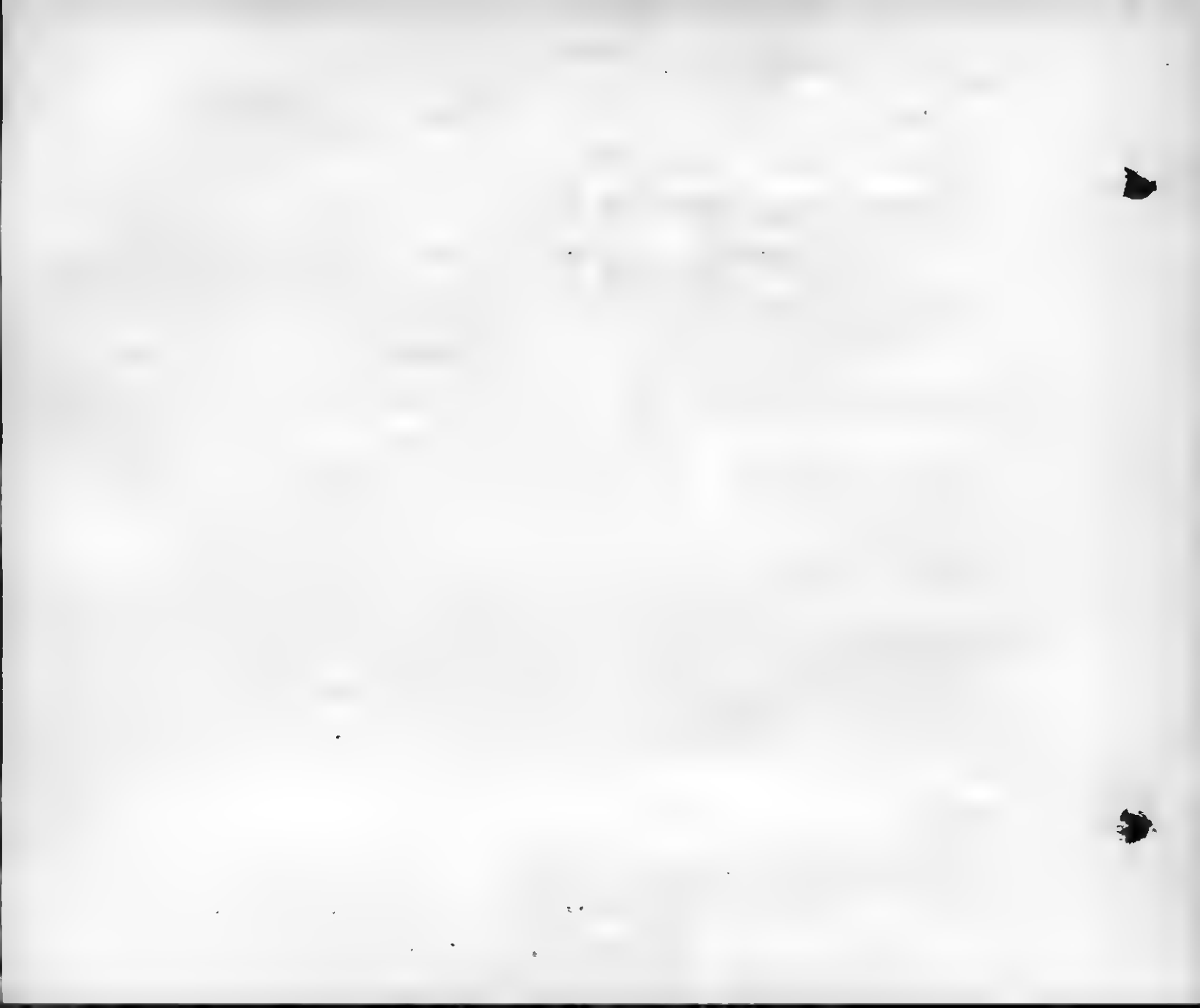
Reg. Dist. No.

10374

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 31 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Gertrude Lee		4. DATE OF DEATH Month Day Year September 23 19 58					
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/08	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lee			14. MOTHER'S MAIDEN NAME Allie Walker				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Pelvic Abscess Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) Pyosalpinx. Ruptured urinary Bladder DUE TO (c) Bronchopneumonia.				INTERVAL BETWEEN ONSET AND DEATH 6 months 2 days 1 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Acetitis -				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 21 , 19 58 , to Sept 23 , 19 58 , that I last saw the deceased alive on Sept 23 , 19 58 , and that death occurred at 9:25 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Richard A. Yates 9-24-58 M.D.							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) R. A. Yates, M. D.					
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF 9/26/58		22c. NAME OF CEMETERY OR CREMATORY Oak Grove.,		22d. LOCATION (City, town, or county) (State) Mt. Zion, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE SEP 26 58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10286

CERTIFICATE OF DEATH

10351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTG</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>MD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellevue Springs Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>LEOPOLD</u> Last <u>LEOPOLD</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-29-1888</u>	
				9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House duties</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SOLOMON BERGER</u>				14. MOTHER'S MAIDEN NAME <u>ESTHER BERGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>None</u>				16. SOCIAL SECURITY NO			
				17. INFORMANT Address <u>MELVIN ROMANCEFF 2807-HARRIS St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LEUKEMIA</u>							<u>3 YRS</u>
204.4 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>55</u> , to <u>Sept 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 19</u> , 19 <u>58</u> , and that death occurred at <u>1A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Simon C. Weiner</u> M D				ADDRESS (Street, city or town, state) <u>100 Longfellow St NW, Hyattsville</u>			
DATE SIGNED <u>Sept 29 1958</u>							
PHYSICIAN'S NAME (Type) <u>Simon C. Weiner</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-21-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Warsawer Relief Soc -</u>		22d. LOCATION (City, town, or county) (State) <u>NEW HAVEN CONN.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash. DC</u> ADDRESS				24a. REC'D BY REGISTRAR <u>SEP 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10352

10375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2212 ROSS RD SILVER SPRING, MD.				d. STREET ADDRESS 2212 Ross Road			
3. NAME OF DECEASED (Type or print) Rose First Levine Middle Levine Last				4. DATE OF DEATH Sept. 15 1958 Month 15 Day 19 Year 58			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 25 1902	9. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Zalman Murnik				14. MOTHER'S MAIDEN NAME Chaya - - -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Sidney Levine Address 2203 Mark Court, Silver Spring, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERIO-SCLEROSIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 6 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from SEPT 15, 1958 to SEPT 15, 1958 , that I last saw the deceased alive on SEPT 15, 1958 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE LeRoy Robins M.D.				ADDRESS (Street, city or town) state 2480 16th St., N.W. DATE SIGNED 9-15-58			
PHYSICIAN'S NAME (Type) LeRoy Robins, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 17, 1958		22c. NAME OF CEMETERY OR CREMATORY ELESAVETGRAD CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON DC	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons ADDRESS 3501 14th St., NW.				24a. REC'D BY REGISTRAR SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thau	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

10376

10353

Reg. Dist. No.

10376

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 2 1/2 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase

d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital

d. STREET ADDRESS 3510 Taylor Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
Jerome J Lightfoot September 1 19 58

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH December 17, 1878 9. AGE (In years last birthday) yrs. 79 IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Wash. D. C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Jerome Lightfoot 14. MOTHER'S MAIDEN NAME Lucy Whelshy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. No 17. INFORMANT Hospital Record Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia and tracheobronchitis 91X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Wrenia 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

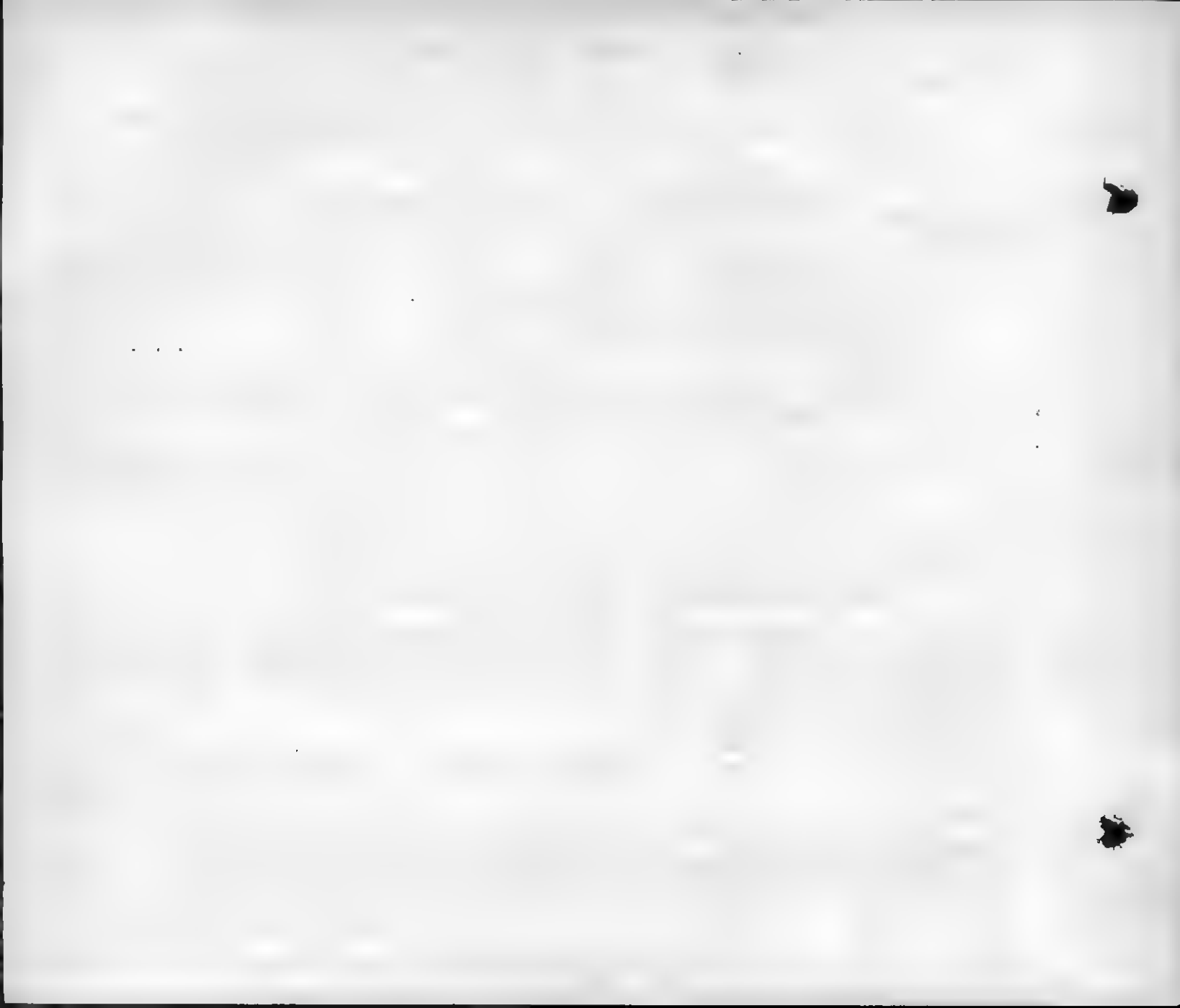
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 28, 1958, to September 1, 1958, that I last saw the deceased alive on August 31, 1958, and that death occurred at 1:20 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Robert H. Poole M.D. 4630 Montgomery Ave., Bethesda, Md. 9/1/58

ACTUAL SIGNATURE Robert H. Poole PHYSICIAN'S NAME (Type) ROBERT N. COHLE

22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION 22b. DATE THEREOF 9/3/58 22c. NAME OF CEMETERY OR CREMATORY GATE HILL CEDAR HILL CREM. SUITLAND MD. 22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR DATE SEP 4 58 24b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10287

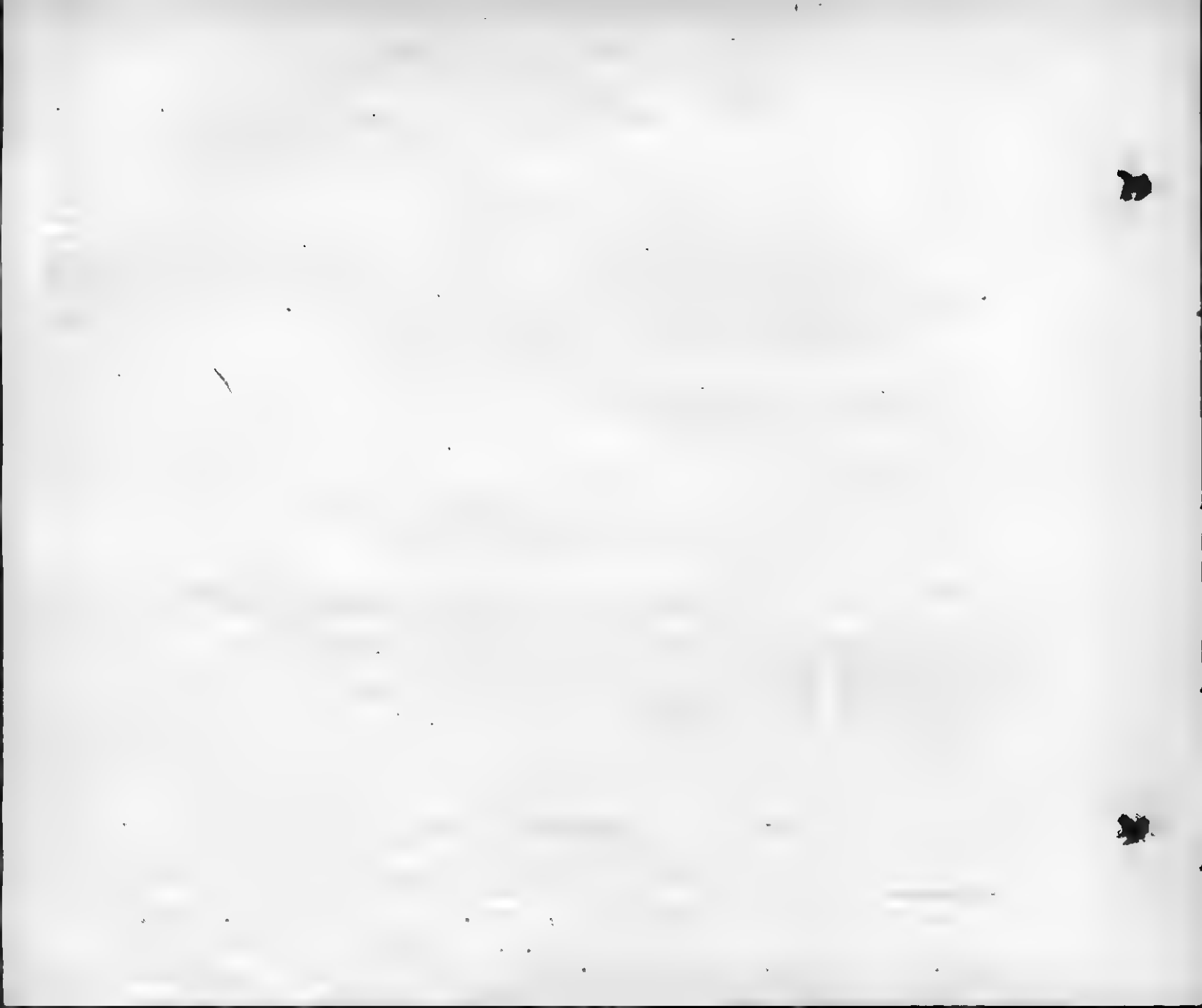
CERTIFICATE OF DEATH

10354

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>6 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8502 Flower Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mamie Florene Lilly</u>		4. DATE OF DEATH Month Day Year <u>September 2 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1866</u>
9. AGE (in years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	
13. FATHER'S NAME <u>James A. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> [? yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>Morgan C. Smith</u>		Address <u>8502 Flower Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 22, 1958</u> to <u>Sept 2, 1958</u> that I last saw the deceased alive on <u>Sept 1, 1958</u> , and that death occurred at <u>1 A. M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Charles W. Humphreys, M.D.</u>		1746 K St. Wash, D.C. 9/4/58	
PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys, Jr.</u>			
22a. BURIAL OR CREMATION REMOVAL (Specify) <u>removal</u>	22b. DATE THEREOF <u>9/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whiteville, Tenn.</u>	22d. LOCATION (City, town, or county) (State) <u>Whiteville, Tenn.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>SEP 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



103555
(10355)

10377

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Maryland		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY Howard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc. 1502 Montgomery Road				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joy		Middle Hazel		Last Lynes		4. DATE OF DEATH Month September		Day 21	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 19, 1958		9. AGE (In years last birthday) yrs 48 Months 48 Days hrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Frederick E. Lynes				14. MOTHER'S MAIDEN NAME Hazel Melson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO None		17. INFORMANT Hazel Lynes		Address 1502 Montgomery Road, Md. ElkrIDGE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CLARKSVILLE		(County) MARYLAND	
20f. (State) MARYLAND		21. I certify that I attended the deceased from 9/19, 1958 to 9/21, 1958 , that I last saw the deceased alive on 9/21, 1958 , and that death occurred at 3:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles S. Whitaker		M.D.		ADDRESS (Street, city or town, state) CLARKSVILLE		DATE SIGNED 9-22-58			
PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.		M.D.		ADDRESS MARYLAND					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-1958		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) Ellicott City, Md		(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE F. G. Higinbotham				ADDRESS Ellicott City, Md		24a. RECEIVED BY REGISTRAR SEP 26 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10356

10288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN IT <u>13 months</u>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp</u>				d. STREET ADDRESS <u>7130 Willow Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-24-1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Washington Sanitarium + Hosp. Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>450.0</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Concomitant Diabetes</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>13 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-6-58</u> , 19 <u>58</u> , and that death occurred at <u>11:00 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7130 Willow Ave. Wash. D.C.</u> DATE SIGNED <u>10/1/58</u>							
ACTUAL SIGNATURE <u>W. B. G. F. A.</u>		M.D. <u>W. B. G. F. A.</u>					
PHYSICIAN'S NAME (Type) <u>W. B. G. F. A.</u>		<u>TAKOMA PARK MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. 2901 14th St., N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>J. L. S. Kraus</u>	



10378

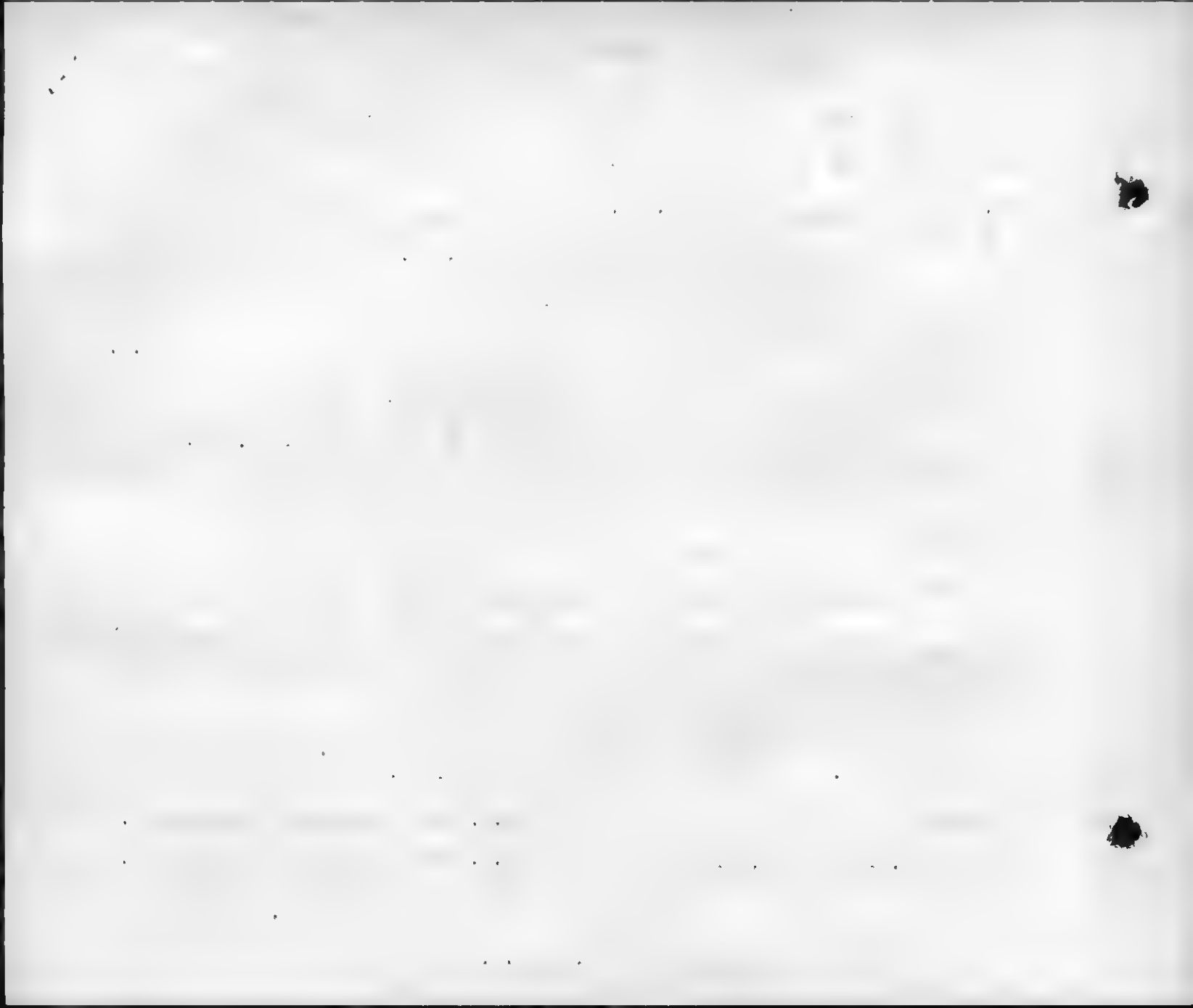
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 225 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Wesley Last MASON, Sr.				4. DATE OF DEATH Month September Day 15 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11 February 1903		9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George MASON				14. MOTHER'S MAIDEN NAME Minnie BOWEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO (If yes, give war or dates of service) WW-II		17. INFORMANT (Son) Harry Wesley Mason, Jr. (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Squamous Cell 140.4 DUE TO 3 week Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 18 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 February , 19 58 , to 15 Sept. , 19 58 , that I last saw the deceased alive on 15 Sept. , 19 58 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-17-58							
ACTUAL SIGNATURE [Signature] M.D.				U.S. Naval Hospital, Bethesda, Md.			
FURNELMAN'S NAME (Type) M.C. SHEA, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Taltavull Funeral Home, 3619 14th St., Wash.D.C.				24a. REC'D BY REGISTRAR DATE SEP 19 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

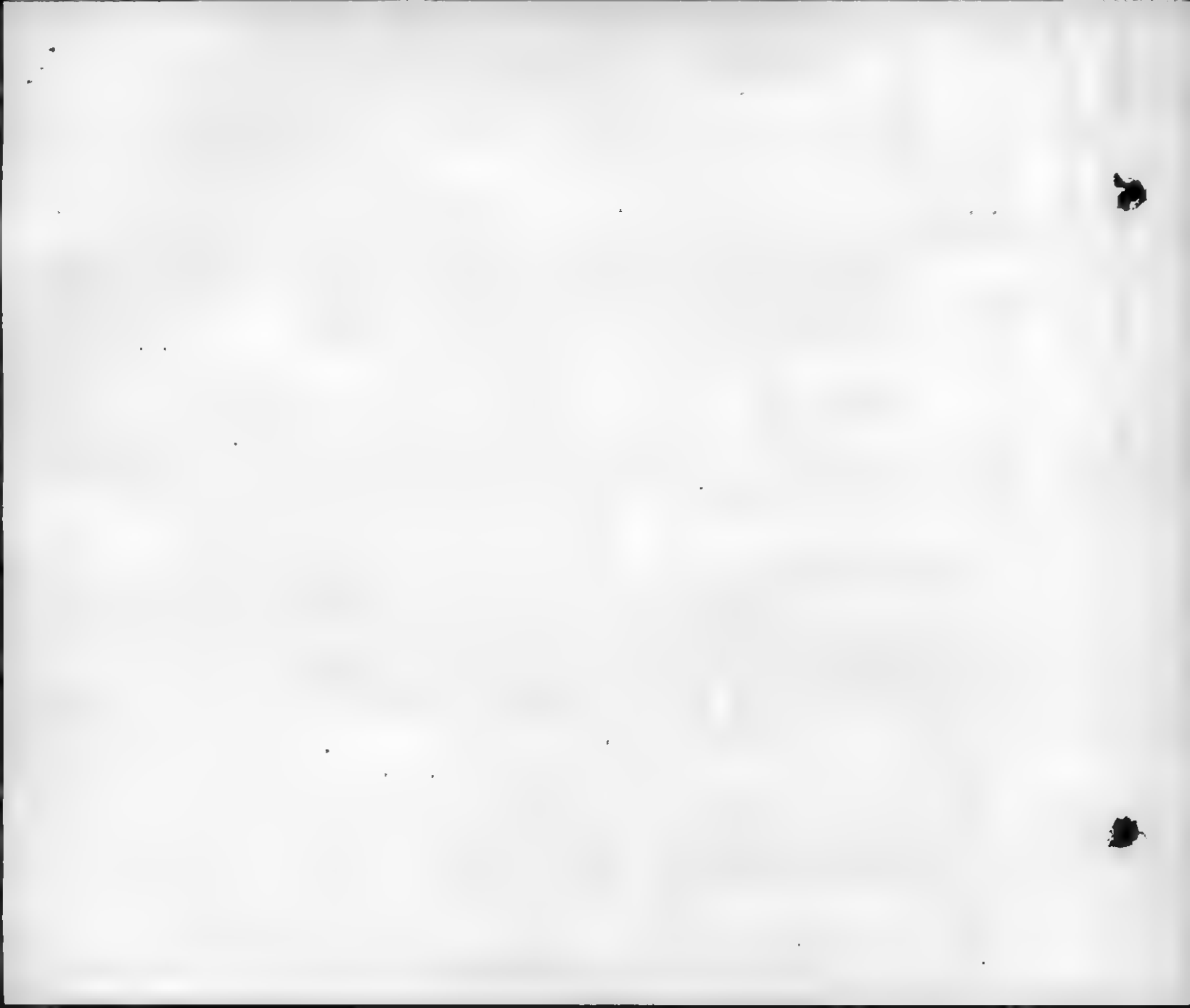
10379

CERTIFICATE OF DEATH

Reg. Dist. No.

10358

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 17 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 4909 Battery Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Diane Middle Katherine Last MC COMB		4. DATE OF DEATH Month September Day 4 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 May 1957
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington State		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Gordon Stuart MC COMB		14. MOTHER'S MAIDEN NAME Donna Margaret GALLEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) (Same As #2) Gordon S. MC COMB		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 7-4-58 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 August , 19 58 , to 4 Sept. , 19 58 , that I last saw the deceased alive on 4 Sept. , 19 58 and that death occurred at 7:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-5-58			
ACTUAL SIGNATURE Robert C. Thomas M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Robert C. Thomas, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-9-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS 7357 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR SEP 9 '58	24b. REGISTRAR'S SIGNATURE C. J. P. Thomas



BALTIMORE, 18

CERTIFICATE OF DEATH

It is 4, Film G234, 10/9/58 for 10289

10359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>70</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ralls Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Takoma Park Bethesda</u> d. STREET ADDRESS <u>5112 Wessling Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EVA</u> First <u>D</u> Middle <u>McDEVITT</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>19 58</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 4, 1886</u> 9. AGE (In years last birthday) <u>72</u> yrs. 10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Downes</u> 14. MOTHER'S MAIDEN NAME <u>Mary J Dyol</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>daughter</u> Address <u>Helen Boyer-4708 Morgan Ln. Bh. Ch. Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>CEREBRAL ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>General Arteriosclerosis</u> (b) <u>General Arteriosclerosis</u> (c) <u>General Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE LEFT FEMUR - AUG. 1958</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u>19</u> p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>SEPT. 19, 47</u> to <u>SEPT. 26, 19 58</u> that I last saw the deceased alive on <u>SEPT. 25, 19 58</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7921 158</u> DATE SIGNED ACTUAL SIGNATURE <u>Robert A. Angle</u> M.D. <u>5009 Dr. Ry Ave. Bethesda, Md.</u> PHYSICIAN'S NAME (Type) <u>ROBERT A. ANGLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>9-29-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery.</u> 22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u> 24a. REC'D BY REGISTRAR <u>SEP 30 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10380

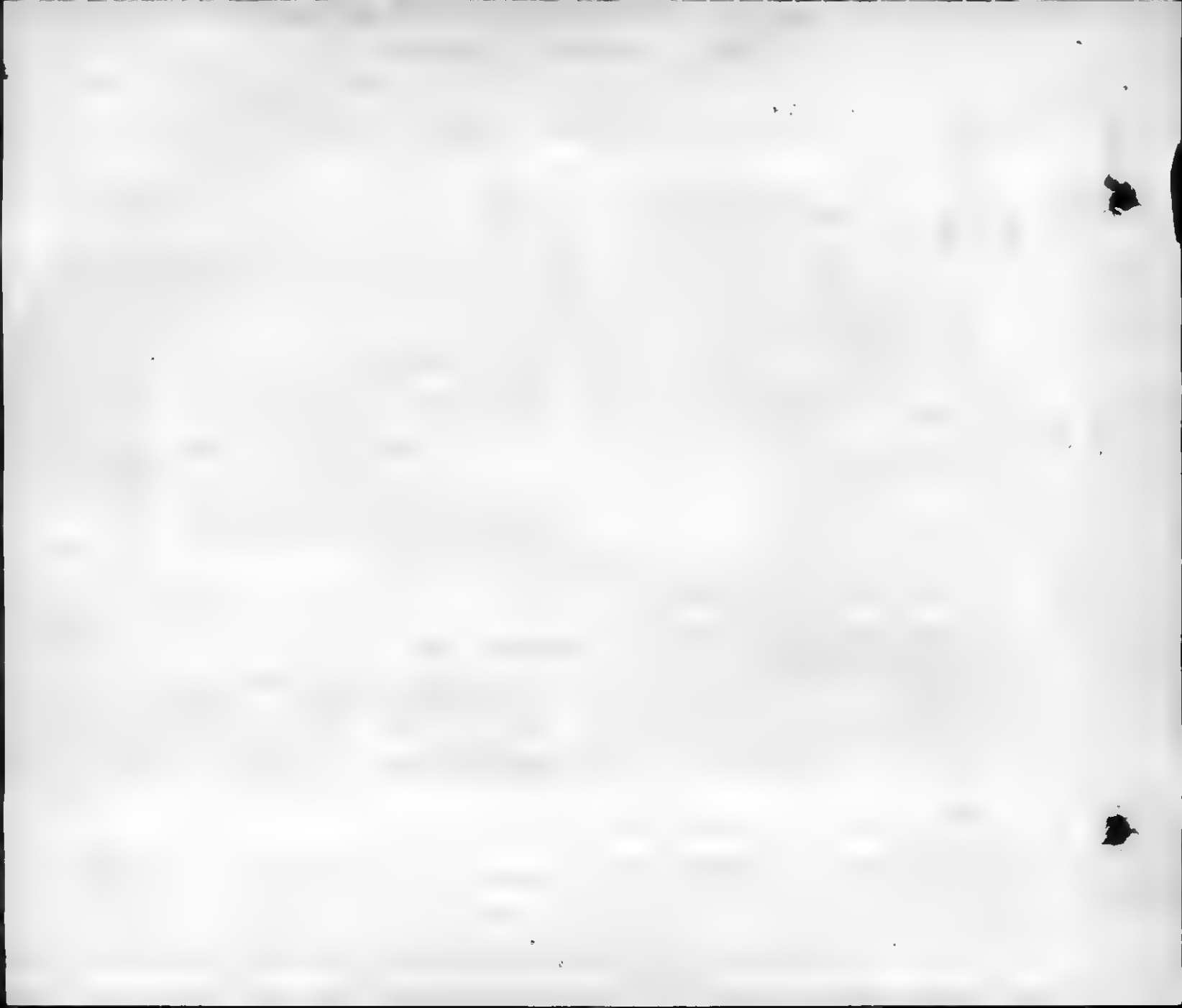
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH o COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 33 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 4209 McCain Court			
3. NAME OF DECEASED (Type or print) First Norma Middle K Last McLaughlin				4. DATE OF DEATH Month September Day 17 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 4, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 10 Days 13 Hours Min. 		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker				10b. KIND OF BUSINESS OR INDUSTRY Georgia		11. BIRTHPLACE (State or foreign country) U.S.A	
13. FATHER'S NAME ROSWELL KING				14. MOTHER'S MAIDEN NAME Mary Clayton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None			
17. INFORMANT Grand daughter (Mrs. John Gomez)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arterial thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis years (c) Hypertensive CVD years						INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic thrombosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 9/1 , 19 58 , to 9/16 , 19 58 that I last saw the deceased alive on 9/16 , 19 58 , and that death occurred at 2:35 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ROCKVILLE, MD. DATE SIGNED 9-17-58							
ACTUAL SIGNATURE G. Bowditch Hunter Jr.							
PHYSICIAN'S NAME (Type) G. BOWDITCH HUNTER JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-Transit		9-17-58		Beech Wood Cemetery.		New Rochelle, New York	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 18 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10381

CERTIFICATE OF DEATH

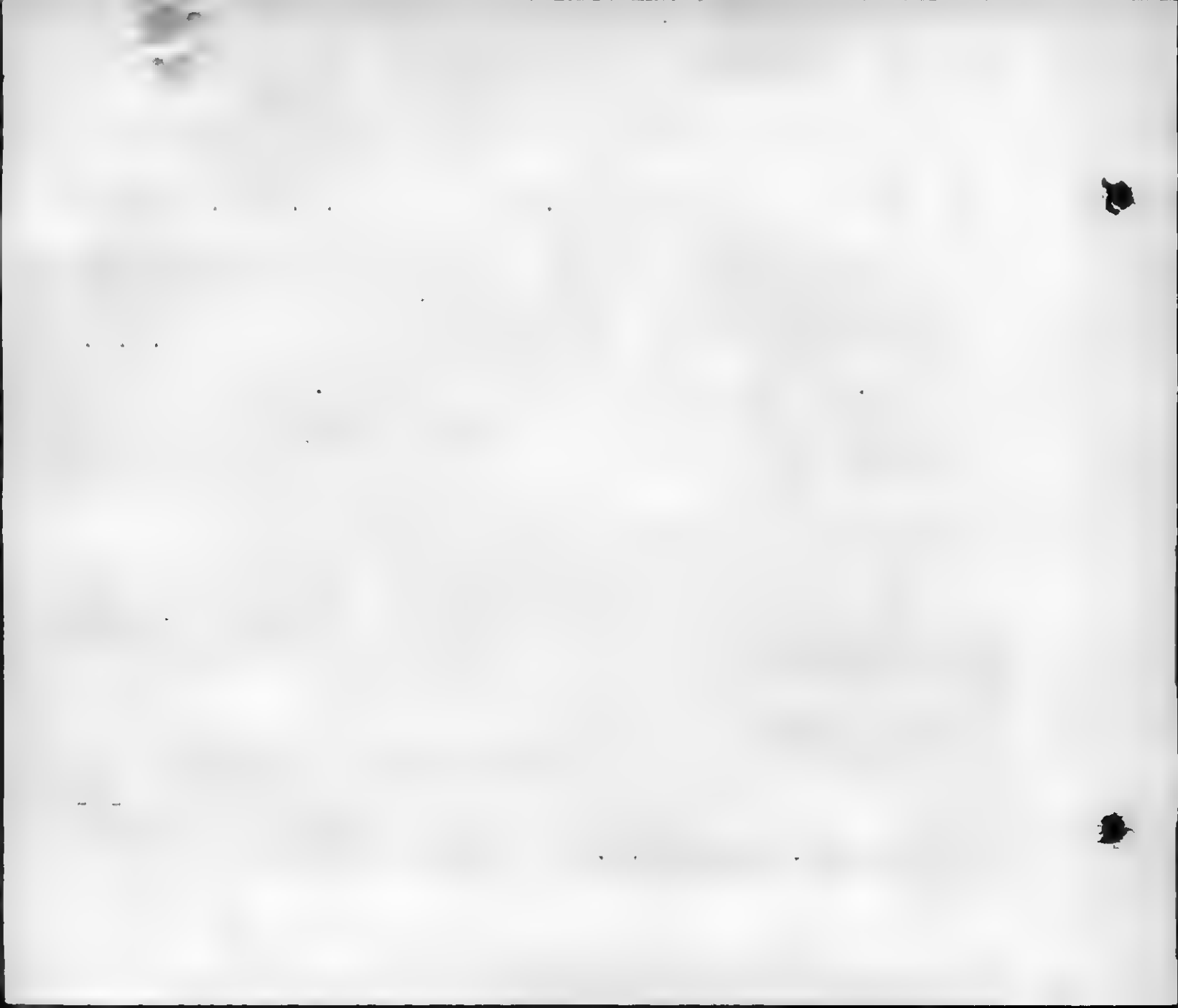
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 69 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 200 C Street, S. E. Apt. 101									
3. NAME OF DECEASED (Type or print) First Frank		Middle Ball		Last Melchior		4. DATE OF DEATH Month September		Day 15		Year 1958	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1897		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY House of Representatives		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME William E. Melchior		14. MOTHER'S MAIDEN NAME Sarah E. Ball									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) YES		16. SOCIAL SECURITY NO 280-22-3454		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asotemia 157 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma, Maxillary DUE TO (c) Carcinoma of pancreas		INTERVAL BETWEEN ONSET AND DEATH 2 wks 6 mos ?									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 8 , 19 58 , to September 15 , 19 58 , that I last saw the deceased alive on September 15 , 19 58 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above.											
ACTUAL SIGNATURE H.R. Silberman		M.D. The Clinical Center		ADDRESS (Street, city or town, state) National Institutes of Health		DATE SIGNED 9-15-58					
PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Amid		22b. DATE THEREOF 17 SEPT 1958		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEM.		22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.					
23. FUNERAL DIRECTOR'S SIGNATURE JAMES T. RYAN, INC.		ADDRESS 317 PA. AVE. S. E. DC 3		24a. RECEIVED BY REGISTRAR SEP 17 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

MEDICAL CERTIFICATION

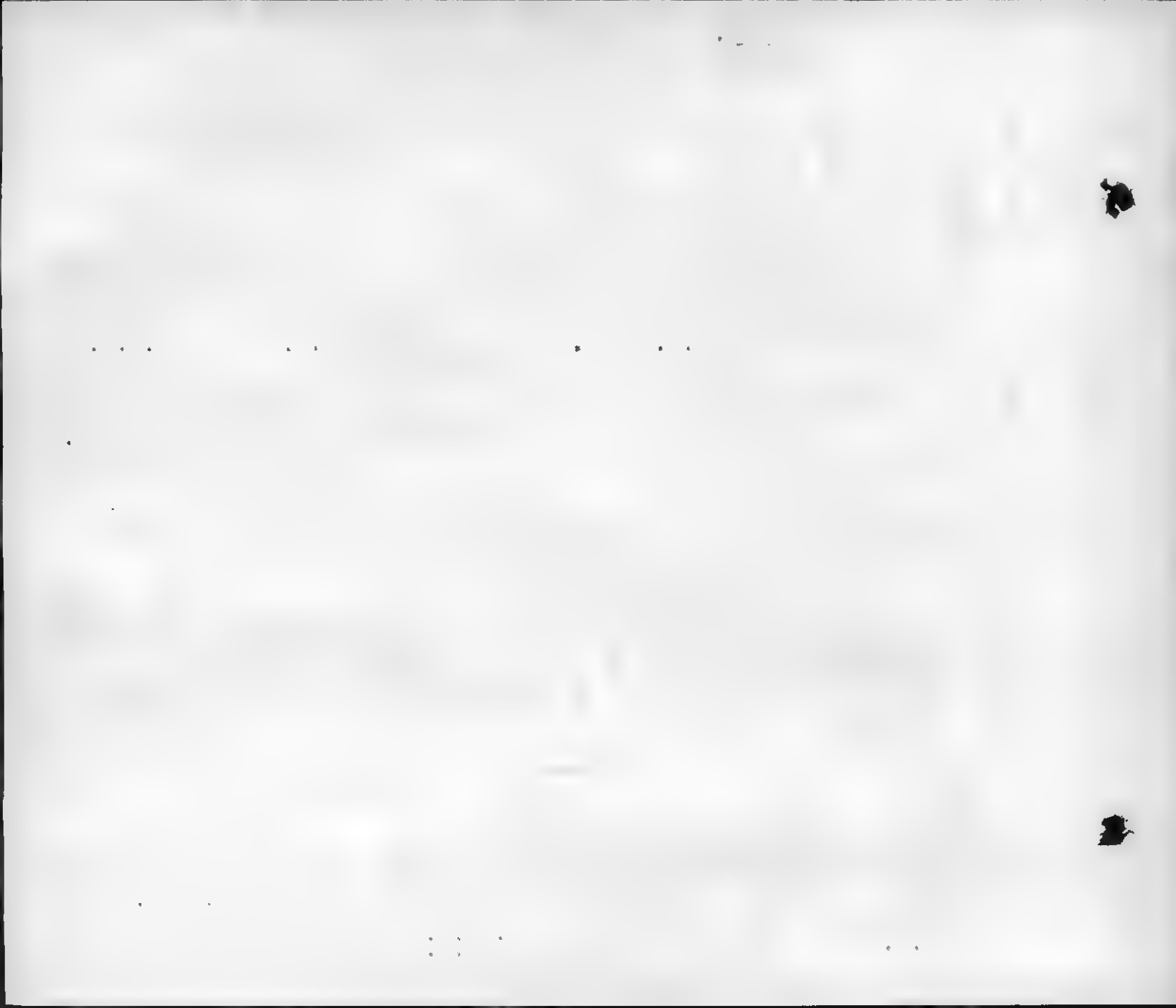
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

VS AIS (4)
35M 9/55



10383

CERTIFICATE OF DEATH

10363

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospt.				d. STREET ADDRESS '713 W. Montg. Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE (NMI) MILLS				4. DATE OF DEATH Month Day Year Sept. 3, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/62		9. AGE (In years last birthday) 96 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME ? Mills				14. MOTHER'S MAIDEN NAME Carolynne Fletcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Mrs Martha M. Looper-Item#2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INSUFFICIENCY DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL INSUFFICIENCY DUE TO NEPHROSCLEROSIS (c) NEPHROSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs 15 yrs 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15 yrs 2 1/2 hrs. before death							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 17, 1958 to September 3, 1958 , that I last saw the deceased alive on September 1, 1958 , and that death occurred at 3:17 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 N. E. 1st St., Rockville, Md. DATE SIGNED Sept 3, 1958							
ACTUAL SIGNATURE Gordon S. Rosenberger M.D.				PHYSICIAN'S NAME (Type) Gordon S. Rosenberger-310 W. Montg. Ave., Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/58		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 14 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10384

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 13 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 809 Crothers Lane	
3. NAME OF DECEASED (Type or print) First Margaret Middle Ellen Last MOORE		4. DATE OF DEATH Month September Day 8 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 March 1894
9. AGE (In years last birthday) yrs 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James BEAL		14. MOTHER'S MAIDEN NAME Ellen BARBER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 011 03 7218	
17. INFORMANT (Daughter) Mrs. Edna M. Smith (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 102.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Possible metastases from bronchogenic cancer DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 August , 19 58 , to 8 Sept. , 19 58 , that I last saw the deceased alive on 8 Sept. , 19 58 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James M. Young M.D.		U.S. Naval Hospital, Bethesda, Md. 9-9-58	
PHYSICIAN'S NAME (Type) James M. Young, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 9-10-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) 4000 Suitland Rd., Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE A. A. Dunlap		ADDRESS 381 Wisconsin Ave., Bethesda, Md.	
24a. REC'D BY REGISTRAR SEP 10 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10385

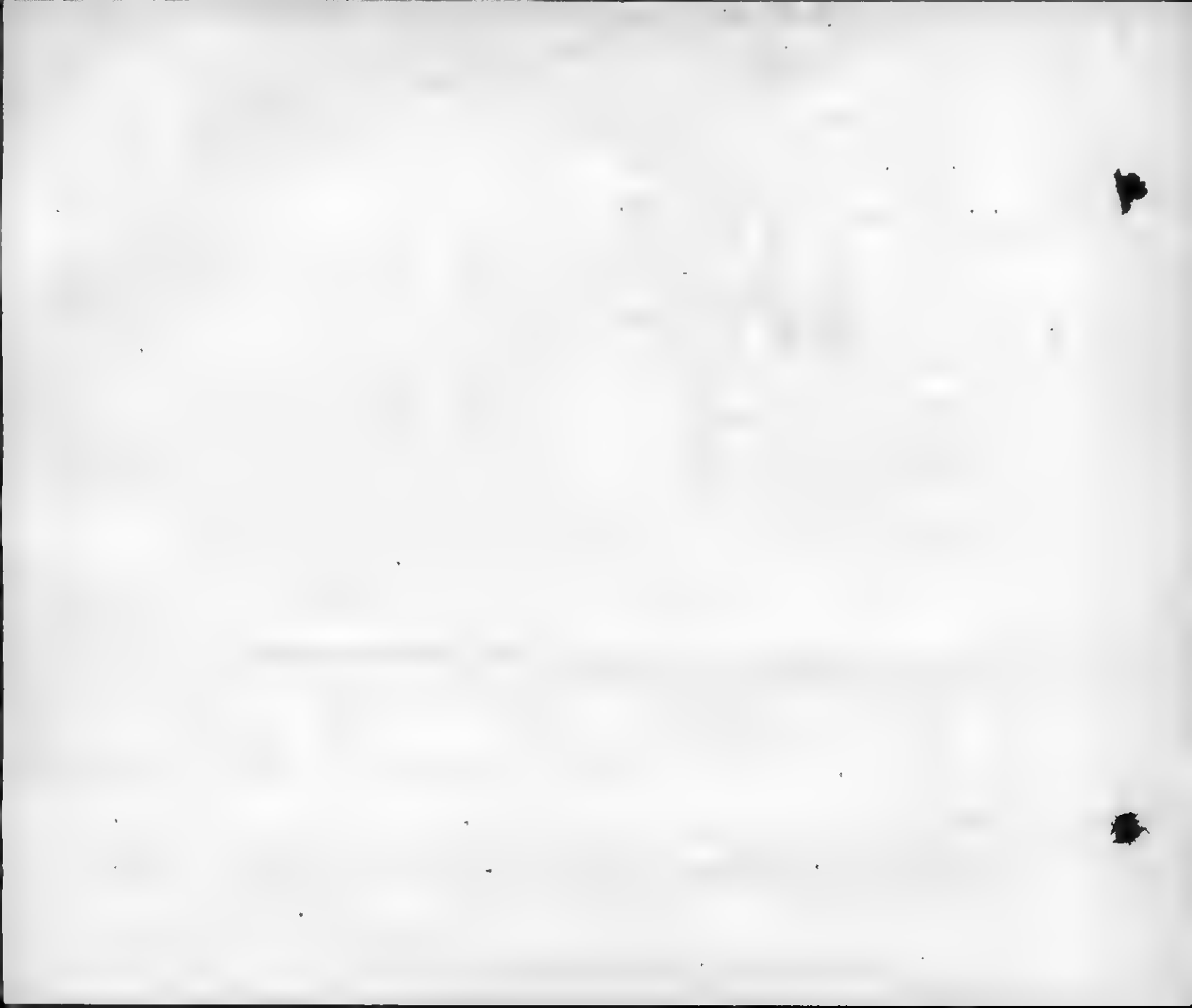
CERTIFICATE OF DEATH

Reg. Dist. No 215

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 53 Days		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Virginia		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church		d. STREET ADDRESS 432 Cross Woods Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) First Middle Last Mary Kathryn MOORE		4. DATE OF DEATH Month Day Year September 1 1958		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 January 1914		9 AGE (In years last birthday) yrs 44		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Colorado		12 CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME William SHAW		14. MOTHER'S MAIDEN NAME Louisa DAWE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17 INFORMANT (Husband) Theophilus MOORE (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hepatic Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Liver Metastasis DUE TO Serous Cystadenocarcinoma, Lt. Ovary with (c) Generalized Metastases		INTERVAL BETWEEN ONSET AND DEATH 3 Weeks		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 July 1958, to 1 September 1958, that I last saw the deceased alive on 1 Sept, 1958, and that death occurred at 2:35 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.		DATE SIGNED 9-2-58		ACTUAL SIGNATURE Thomas B. Lebhertz		PHYSICIAN'S NAME (Type) Thomas B. Lebhertz, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.		22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF 9-4-58		22c NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons, 1756 Penn. Ave., Wash, D.C.		ADDRESS 24a. REG. BY REGISTRAR DATE		24b REGISTRAR'S SIGNATURE Arthur S. Thoms		VS A15 (4) 15M 10/57													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

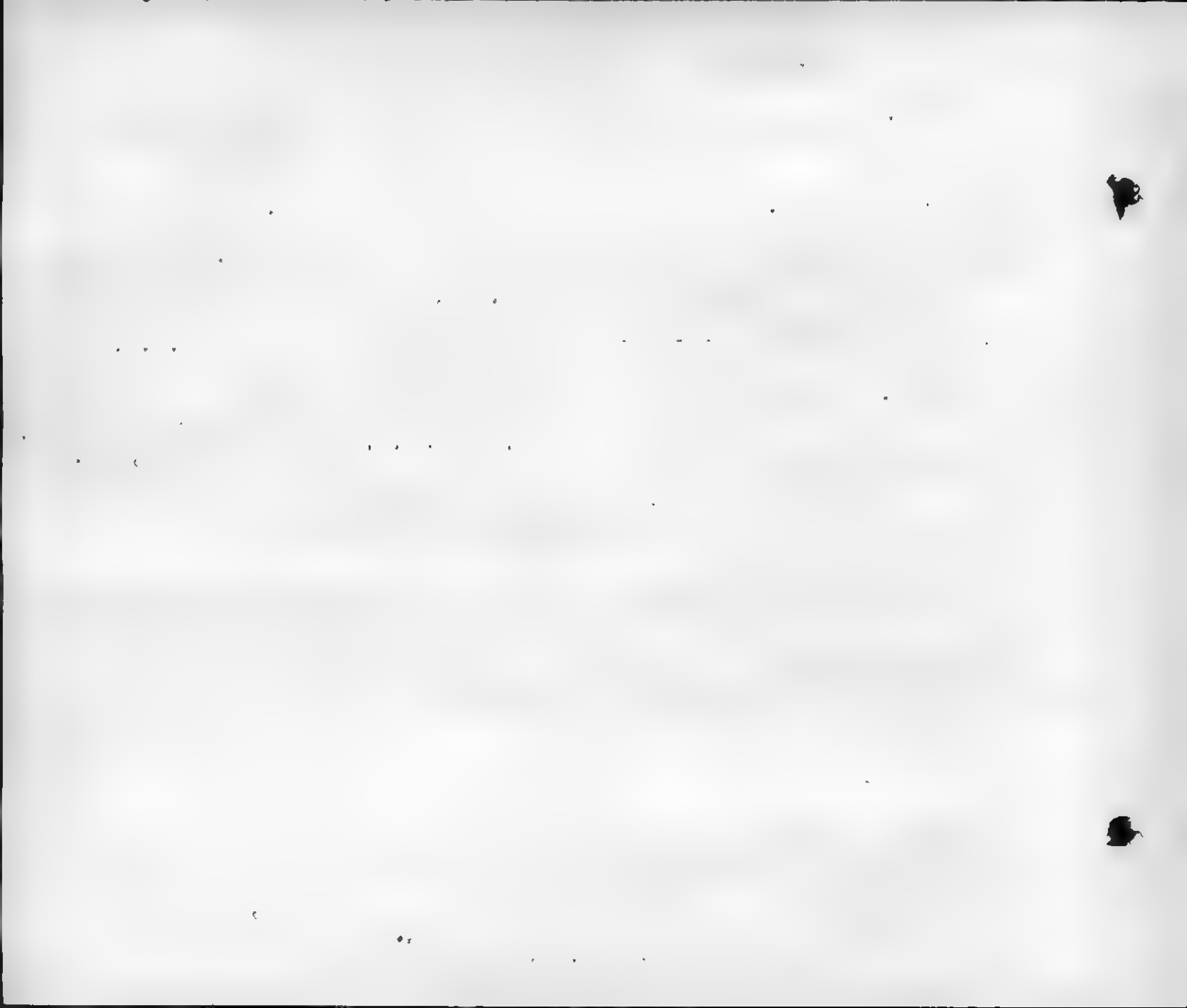
10366

10386

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONT. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 Wellesley Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NANNIE Middle E Last MOORE		4. DATE OF DEATH Month Sept. Day 16 Year 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH aug. 12, 1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY -- -- --	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Liddy		14. MOTHER'S MAIDEN NAME Mary Elmira Walrath	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs. Ruth E.M. Long		Address 200 Wellesley Ave. Glen Echo, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 13 yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to Sept. , 19 58 , that I last saw the deceased alive on Sept. 14 , 19 58 , and that death occurred at 11:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo I. Donovan		DATE SIGNED 9/17/58	
PHYSICIAN'S NAME (Type) LEO I. DONOVAN M.D.		ADDRESS (Street, city or town, state) 2016 Georgetown Road Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Gorkis		ADDRESS 1756 Pa. Ave. NW, DC	
24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. [illegible]	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10367

10387

Reg. Dist No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville</u> c. LENGTH OF STAY IN 1b <u>50 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clara Thomas Morningstar</u>				4. DATE OF DEATH Month Day Year <u>Sept 22 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 22 1879</u> <u>79</u> yrs.		9. AGE (In years last birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William Morningstar</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Buckley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mrs Russell Kinna, Cornus, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Severance of Heart. Arterial artery (rt)</u> DUE TO (c) <u>laceration of scalp</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of 2nd, 3rd & 4th ribs (left)</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell down stair step at home</u>							
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>9:22 1958</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Barnesville Monty Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9-22-58</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept 24-58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>				22d. LOCAT ON (City, town, or county) (State) <u>Barnesville Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Barnesville Md</u>				24a. REC'D BY REGISTRAR <u>SEP 25 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>William S. Kenna</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and no later than 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film 9228 9-15-58 pt.

10388

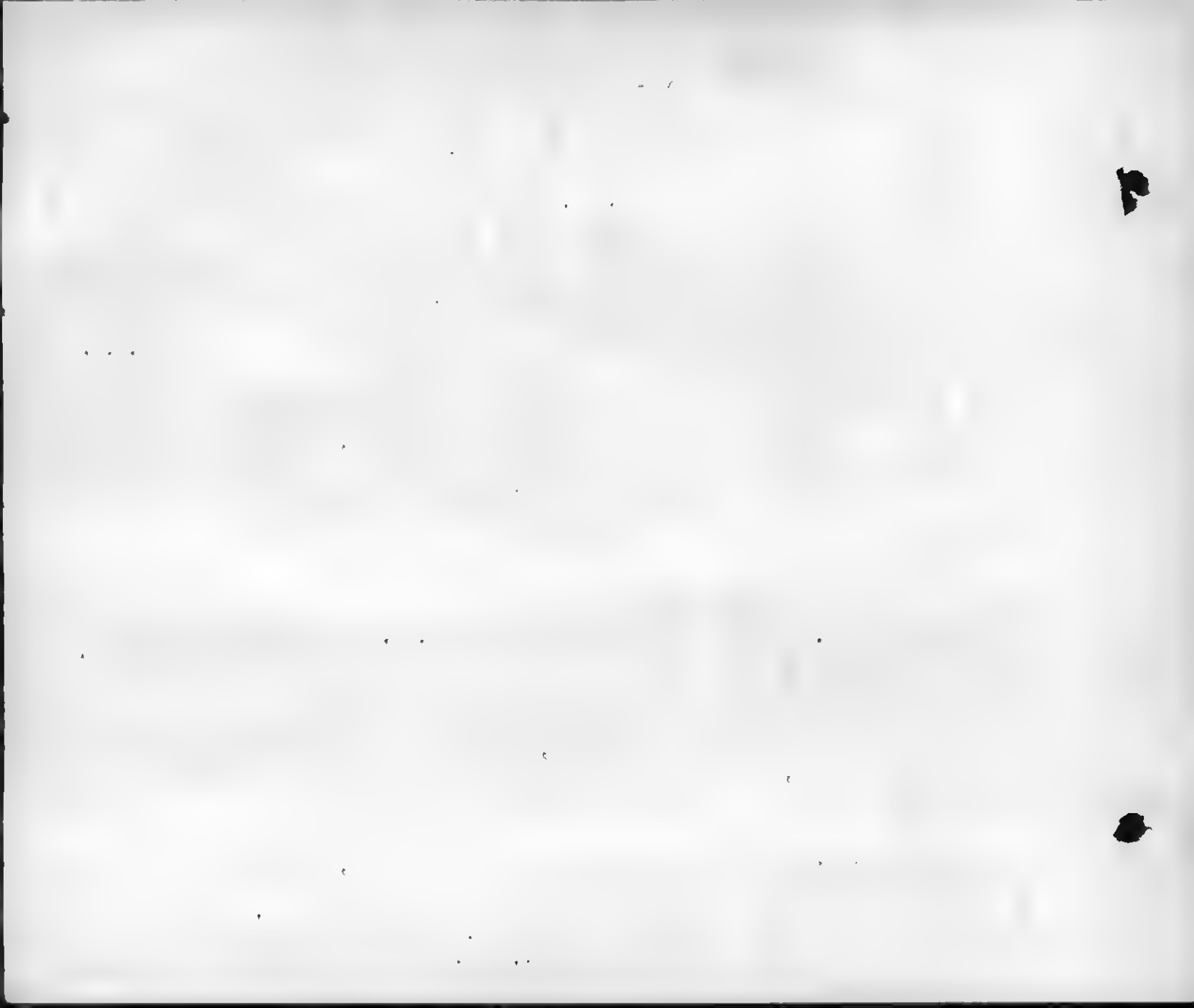
CERTIFICATE OF DEATH

Reg. Dist. No.

10368

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1334 South 28th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Robert Clayton Last Morrison		4. DATE OF DEATH Month September Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1904
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours M n	IF UNDER 24 HRS Hours M n
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advisor		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Manitoba		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman Morrison		14. MOTHER'S MAIDEN NAME Rachel (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage, Perforation of Intestines and Peritonitis DUE TO Intestines and Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic Hypertensive Cardiovascular Disease: a. Recent Myocardial Infarction. b. Chronic Congestive Heart Failure. c. Peripheral Arterial Insufficiency.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 13, 1958 to September 5, 1958 , that I last saw the deceased alive on September 5, 1958 , and that death occurred at 2:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED 9/6/58			
ACTUAL SIGNATURE G. O. Barnett M.D.			
PHYSICIAN'S NAME (Type) G. O. BARNETT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-9-58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W. B. Mountcastle ADDRESS Resident Home Va. Cameron & Alfred Sts., Alex.		24a. REC'D BY REGISTRAR DATE SEP 8 '58	24b. REGISTRAR'S SIGNATURE Robert S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10369

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10389

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State and of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Washington Grove</u>		c. LENGTH OF STAY IN lb <u>Washington Grove</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>321 Brown St.</u>		e. STREET ADDRESS <u>321 Brown St</u>	
3. NAME OF DECEASED (Type or print) <u>Vernon William Moses</u>		4. DATE OF DEATH <u>Sept. 12, 1958</u>	
5. SEX <u>36</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/21</u>
9. AGE (In years last birthday) <u>36</u> yrs		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>painter</u>		12. KIND OF BUSINESS OR INDUSTRY <u>auto.</u>	
13. BIRTHPLACE (State or foreign country) <u>Wt. Leb. Va.</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>William Moses</u>		16. MOTHER'S MAIDEN NAME <u>Sarah Keefer</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		18. SOCIAL SECURITY NO <u>285 28 5114</u>	
19. INFORMANT <u>Mary Doss Moses</u>		Address <u>321 Brown St, Washington Grove, Md.</u>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & Laceration</u> DUE TO (b) <u>Compound fracture of skull</u> DUE TO (c) <u>Shot gun wound</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>981X</u>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Self inflicted shot gun wound of skull (head decapated)</u>	
23. TIME OF INJURY Month, Day, Year <u>11:30 p.m. 9/12/58 19</u>		24. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		26. (City or town) <u>Washington Grove</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>9/13/58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
28. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		29. DATE THEREOF <u>9-13-58</u>	
30. NAME OF CEMETERY OR CREMATORY <u>Gilgal Cemetery</u>		31. LOCATION (City, town, or county) <u>Wt. Leb. Va.</u> (State) <u>VA.</u>	
32. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u>		ADDRESS <u>Gaithersburg, Md.</u>	
33. REC'D BY REGISTRAR <u>SEP 16 '58</u>		34. REGISTRAR'S SIGNATURE <u>Carlton J. House</u>	



10390

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Clagettsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Clagettsville			
c. LENGTH OF STAY in 1b Years				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD Monrovia			
/d STREET ADDRESS RFD Monrovia				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ollie Middle W. Last Moxley				4. DATE OF DEATH Month Sept. Day 18 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1880		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Clagettsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Moxley				14. MOTHER'S MAIDEN NAME Sarah Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mr. Raymond M. Moxley, Monrovia, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease - Coronary Arteriosclerosis 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				20f. (City or town) Clagettsville		(County) (State)	
21. I certify that I attended the deceased from Sept. 18, 1958 to Sept. 18, 1958 , that I last saw the deceased alive on Sept. 18, 1958 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Clagettsville, Md.			
PHYSICIAN'S NAME (Type) James P. Kerr				M.D. James P. Kerr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 20, 1958		22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		22d. LOCATION (City, town, or county) (State) Clagettsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. L. Moleworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR SEP 22 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 shall be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10391

CERTIFICATE OF DEATH

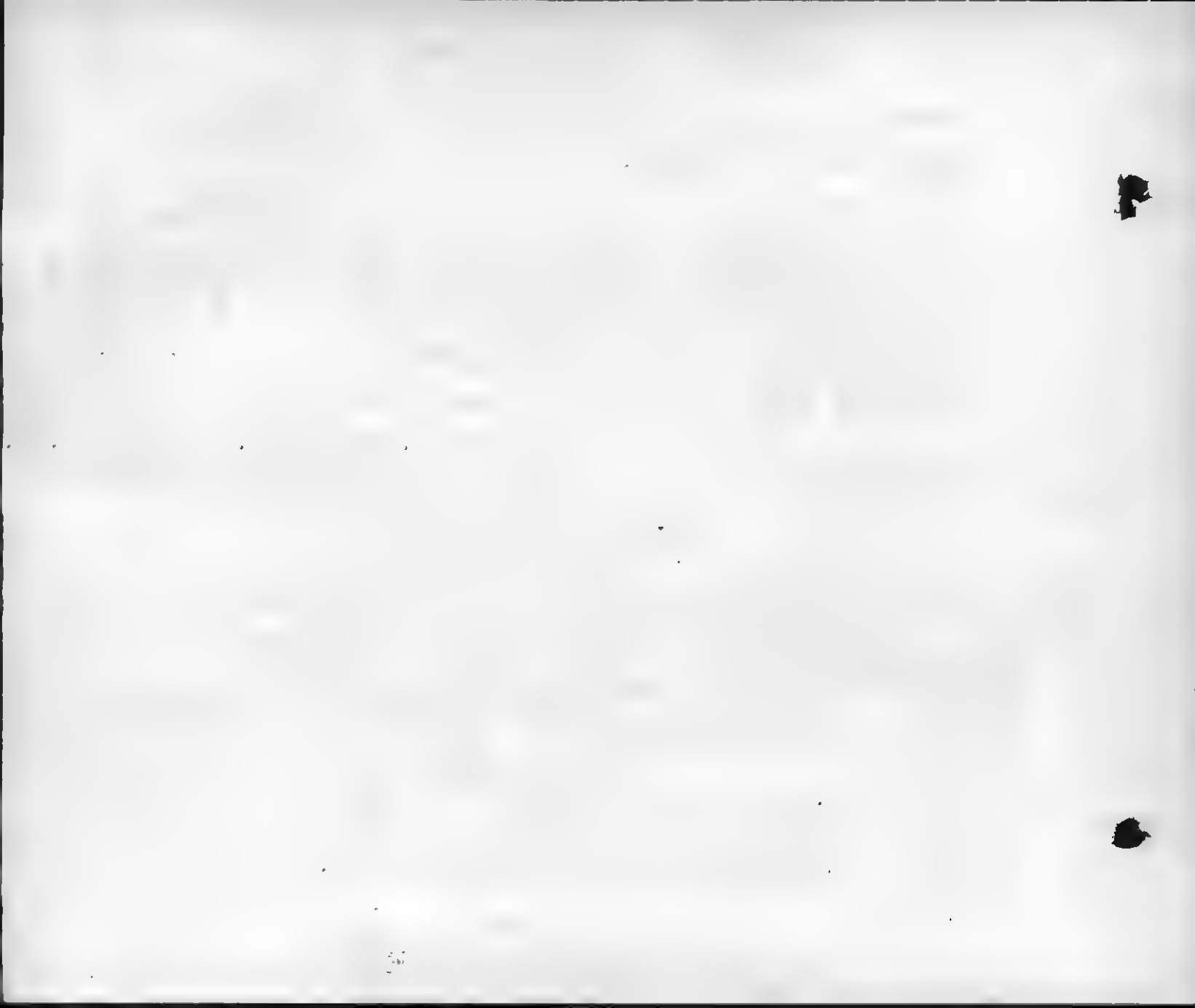
10371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring	
c. LENGTH OF STAY IN 1b 5 mo.		d. STREET ADDRESS Box 141 Brooke Grove Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Norma Middle Jean Last Mullen		4. DATE OF DEATH Month September Day 18 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/7/58
9. AGE (In years last birthday) yrs 5 Months 12 Days 18 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Norman Eugene Mullen	
14. MOTHER'S MAIDEN NAME Merle Elaine Hopkins		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Montgomery Co. General Hosp. Records, Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus 491X DUE TO (b) Lobar pneumonia DUE TO (c) Bronch pneumonia		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Mesenteric Lymphadenitis	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 7 19 58 to Sept 18 19 58 , that I last saw the deceased alive on Sept 17 19 58 , and that death occurred at 2:00 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Maryland DATE SIGNED 9/18/58			
ACTUAL SIGNATURE C. H. Ligon, M. D. M. D.			
PHYSICIAN'S NAME (Type) C. H. Ligon, M. D. Sandy Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9/20/58	Sandy Spring	Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24a. REC'D BY REGISTRAR SEP 24 58	
ADDRESS Rockville, Md		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55



10393

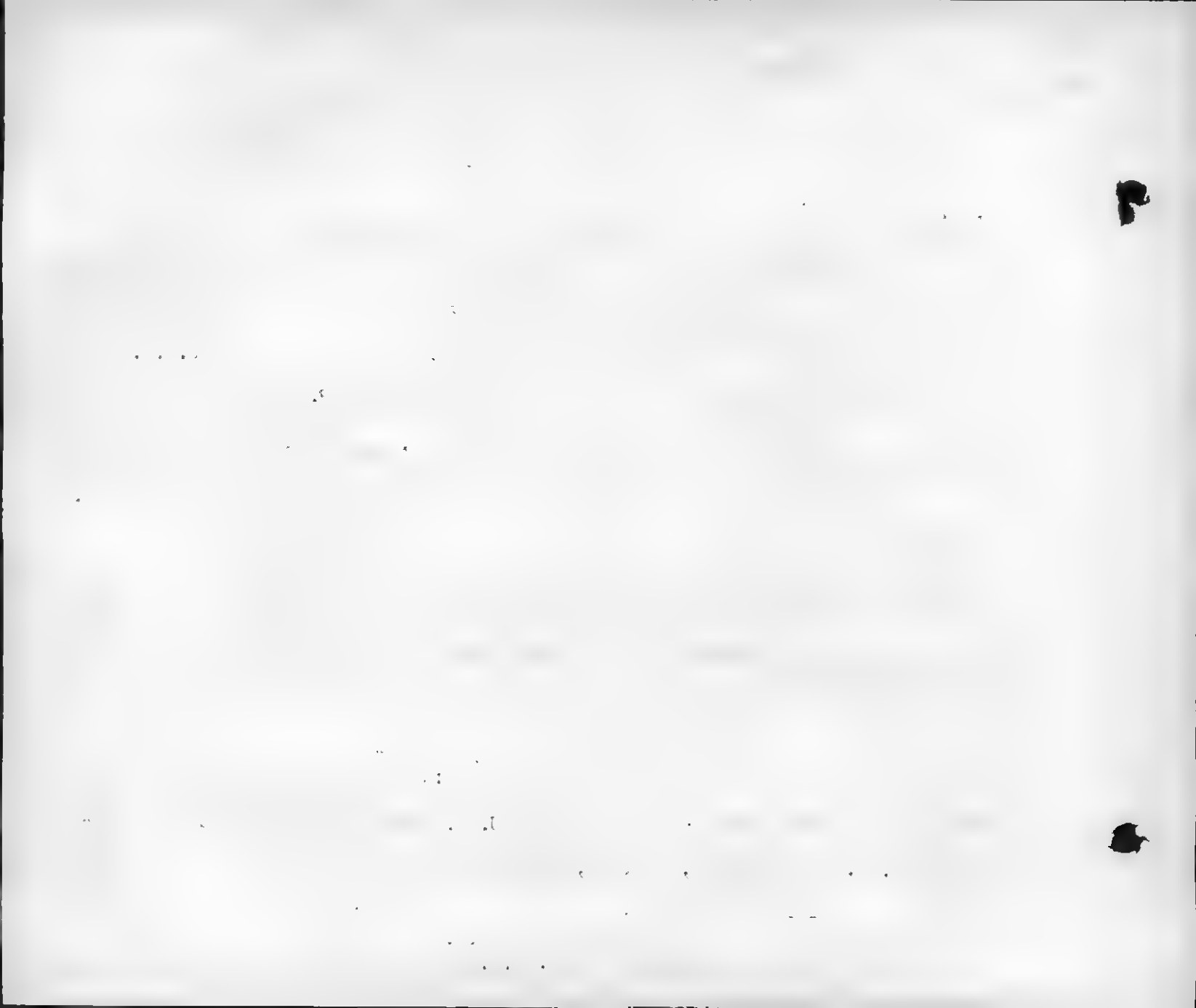
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived (If institution Residence before admission) a. STATE Delaware b. COUNTY Dover	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS RD #4	
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Ann MUSPRATT		4. DATE OF DEATH Month Day Year September 30 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1958
9. AGE (In years last birthday) yrs 6		IF UNDER 1 YEAR Months Days Hours Min 6	IF UNDER 24 HRS Hours Min 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Paul Alexander MUSPRATT	
14. MOTHER'S MAIDEN NAME Loretta Rebecca PULLEN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Father, Paul A. Muspratt, same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7540 IMMEDIATE CAUSE (a) Tetralogy of Fallot DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-24- 1958 , to 9-30 , 1958 , that I last saw the deceased alive on 9-30 , 1958 , and that death occurred at 2:40P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. E. McClenathan</i>		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC	
PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN Bethesda 14, Maryland		DATE SIGNED 10-1-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-5-58	22c. NAME OF CEMETERY OR CREMATORY Silver Brook Cemetery	22d. LOCATION (City, town, or county) (State) Wilmington Delaware
23. FUNERAL DIRECTOR'S SIGNATURE <i>Adams Funeral Home</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Fiana</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10374

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY IN TB <u>12 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4105 Sycamore St</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>4105 Sycamore St</u>	
3. NAME OF DECEASED (Type or print) <u>LILIAN</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-9-1902</u> 9. AGE (in years last birthday) <u>56</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH <u>Sept 30</u> 19 <u>58</u> 13. FATHER'S NAME <u>Wm Haigh</u> 14. MOTHER'S MAIDEN NAME <u>Lillian Cox</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO <u>NONE</u> 17. INFORMANT <u>Joan Nichol</u> Address <u>3508 O St, Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>977x Hemorrhage</u> DUE TO (b) <u>lacerations of left wrist</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>—</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple sclerosis 3 or 4 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE, AS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>Self-inflicted laceration of left wrist</u> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> 20c. TIME OF INJURY Month, Day, Year <u>9-30-58</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) <u>home</u> 20f. (City or town) <u>Cherry Chase</u> (County) <u>Montgomery</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> EXAMINER'S NAME (Type) <u>FRANK J. BROSCHELT</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-30-58</u> DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>10-3-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> 22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State) <u>—</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u> 24a. REC'D BY REGISTRAR <u>2-58</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10395 **CERTIFICATE OF DEATH**

Items 2, 11, 13, 14 Film 6234 10-15-58 et

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Monte</u>	MARYLAND	STATE <u>?</u>	COUNTY <u>?</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>?</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Marilee West Home, 1011 1st St. Silver Spring</u>		STREET ADDRESS <u>?</u>	(If rural give location)
3. NAME OF DECEASED (Type or Print) <u>Catherine</u> (First) <u>Smith</u> (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 27</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>81</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Dr. D. D. Smith, Silver Spring</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
221X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>			<u>5 days</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Involved arteriosclerosis</u>			<u>3 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-3</u>, 19<u>58</u>, to <u>9-27</u>, 19<u>58</u>, that I last saw the deceased alive on <u>9-25</u>, 19<u>58</u>, and that death occurred at <u>1 PM</u>, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>9-27-58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10-1</u>	NAME OF CEMETERY OR CREMATORY <u>Monte, Md.</u>	LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
24. REC'D BY REGISTRAR <u>[Signature]</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Baltimore</u>	
DATE <u>OCT 2 '58</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10396

CERTIFICATE OF DEATH

10370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Steven Last Offutt		4. DATE OF DEATH Month September Day 24 Year 19 58					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/45	9. AGE (In years last birthday) 13 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerome Offutt				14. MOTHER'S MAIDEN NAME Mary Loretta Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Bacterial 7441 DUE TO Bronchio Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pseudo Hypertrophic DUE TO Muscular Dystrophy (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X						INTERVAL BETWEEN ONSET AND DEATH 4 days 11 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 21, 1958 , to Sept. 24, 1958 , that I last saw the deceased alive on Sept. 24, 1958 , and that death occurred at 9:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Schumacher M.D.				DATE SIGNED Sept. 25 1958			
PHYSICIAN'S NAME (Type) Dr. Jack Schumacher				Gaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 27-58		22c. NAME OF CEMETERY OR CREMATORY St Mary's		22d. LOCATION (City, town, or county) (State) Barnesville Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton				ADDRESS Barnesville, Md.		24a. REC'D BY REGISTRAR: SEP 29 58 DATE	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

CERTIFICATE OF DEATH

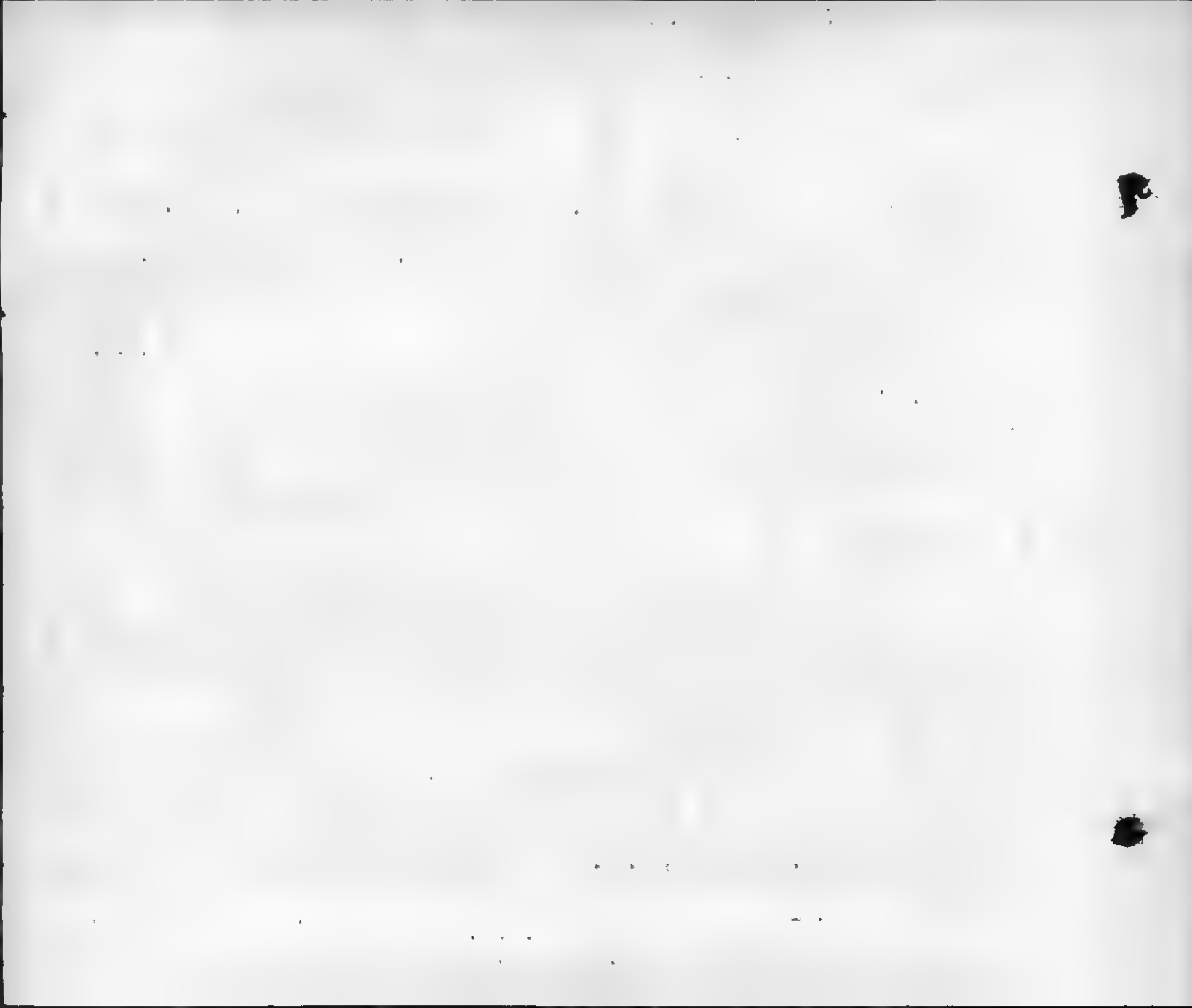
10377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 57 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle William Last O'Hara, Sr.				4. DATE OF DEATH Month September Day 4 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 July 1887	
9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Agent				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James J. O'Hara				14. MOTHER'S MAIDEN NAME Ellen Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW I 706-14-8228		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest - cerebral ischemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) uremia DUE TO (c) hypertension							
INTERVAL BETWEEN ONSET AND DEATH 6 weeks							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 9, 1958 , to September 4, 1958 , that I last saw the deceased alive and September 4, 19 58 , and that death occurred at 9:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Eugene B. Feigelson				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/5/58			
PHYSICIAN'S NAME (Type) Eugene B. Feigelson, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-2-58		22c. NAME OF CEMETERY OR CREMATORY CS. ELIZABETH CEM.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Collins ADDRESS 14th. St. N.W.				24a. REC'D BY REGISTRAR SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10398

CERTIFICATE OF DEATH

Reg. Dist. No. 10378

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution/Residence before admission) o STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10617-EDGEWOOD AVE.</u>				d. STREET ADDRESS <u>10617-EDGEWOOD AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>P. V.</u> Last <u>O'HARA</u>				4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 25, 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WHOLESALE BUS.</u>		11. BIRTHPLACE (State or foreign country) <u>WINCHESTER MASS.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>FRANCIS J. O'HARA</u>				14. MOTHER'S MAIDEN NAME <u>JANE DONAHUE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>010-10-8556</u>			
17. INFORMANT <u>THOMAS FORD</u>				Address <u>10617-EDGEWOOD AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY ASPIRATION-VOMITUS</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC SENILITY</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <u>NONE</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>4 YRS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>X</u> <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>				20f. (City or town) (County) (State) <u>X</u>			
21. I certify that I attended the deceased from <u>7/7</u> , 19 <u>58</u> , to <u>9/29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/25</u> , 19 <u>58</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>10011 Georgia Ave Silver Spring Maryland</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Henry W. Stout MD.</u> PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT</u>							
22a. BURIAL, CREMATION, or other disposition of body <u>buried</u>		22b. DATE THEREOF <u>10-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulen</u>				24a. REC'D BY REGISTRAR DATE <u>3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. L. Haulen</u>	



10399

CERTIFICATE OF DEATH

Reg. Dist. No.

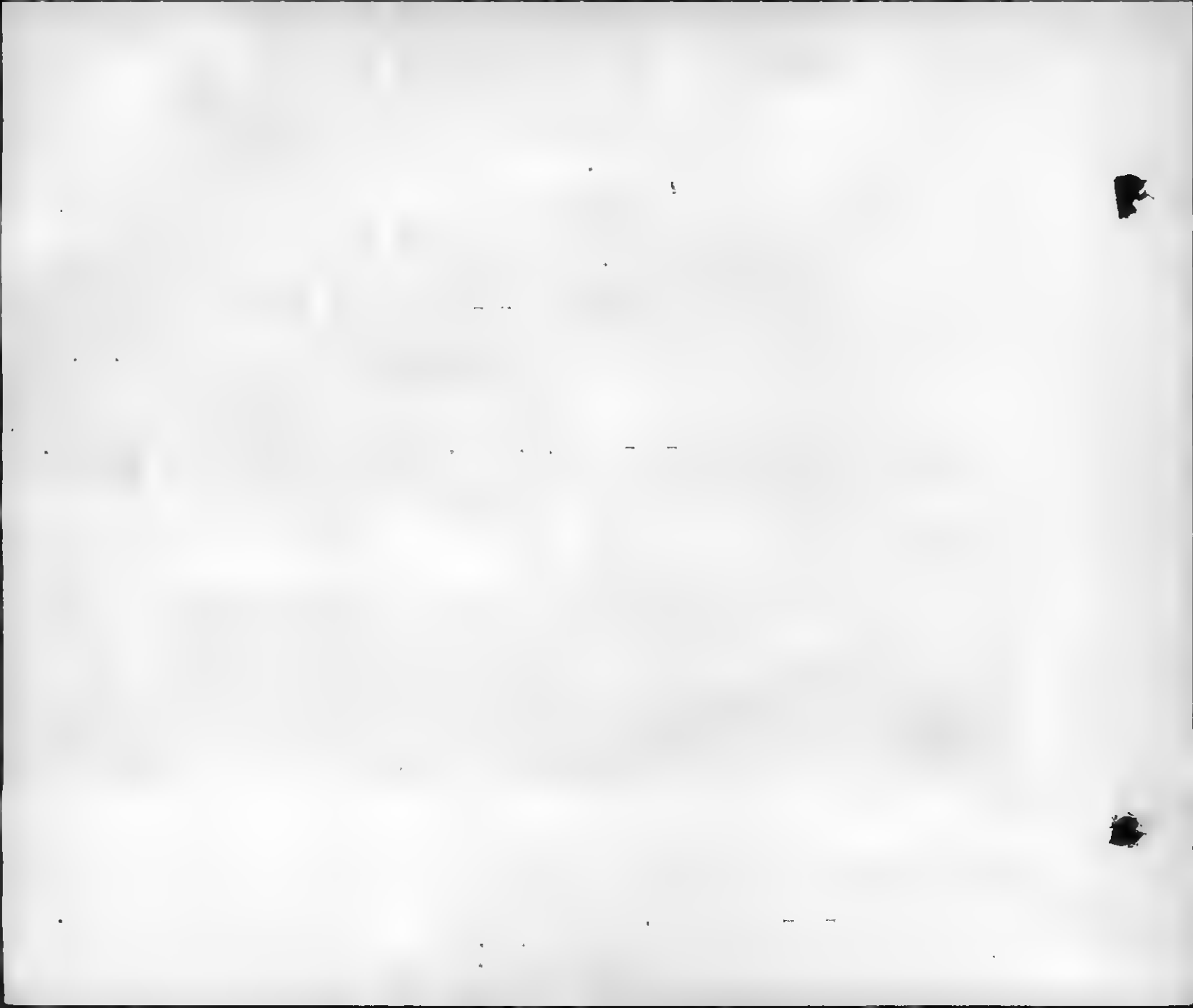
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8904 FLOWER AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANDREW Middle F. Last OTT				4. DATE OF DEATH Month 9 Day 26 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-1-86	
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machanist				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JOHN OTT				14. MOTHER'S MAIDEN NAME LOUISE SCHULER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 216-32-9167		17. INFORMANT WRS. S.M. DEFFINBAUGH Address SILVER SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) Generalized Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/30 1954 to 9/26 1958 , that I last saw the deceased alive on 9/26 1958 , and that death occurred at 1218 M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. C. Leonardo M.D. 5801-1378 J. H. W.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) A. C. LEONARDO							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Collins ADDRESS WASH. D. C.				24a. REC'D BY REGISTRAR SEP 30 '58		24b. REGISTRAR'S SIGNATURE William E. Harris	
FRANCIS J. COLLINS 33821 14th, St. N. W.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

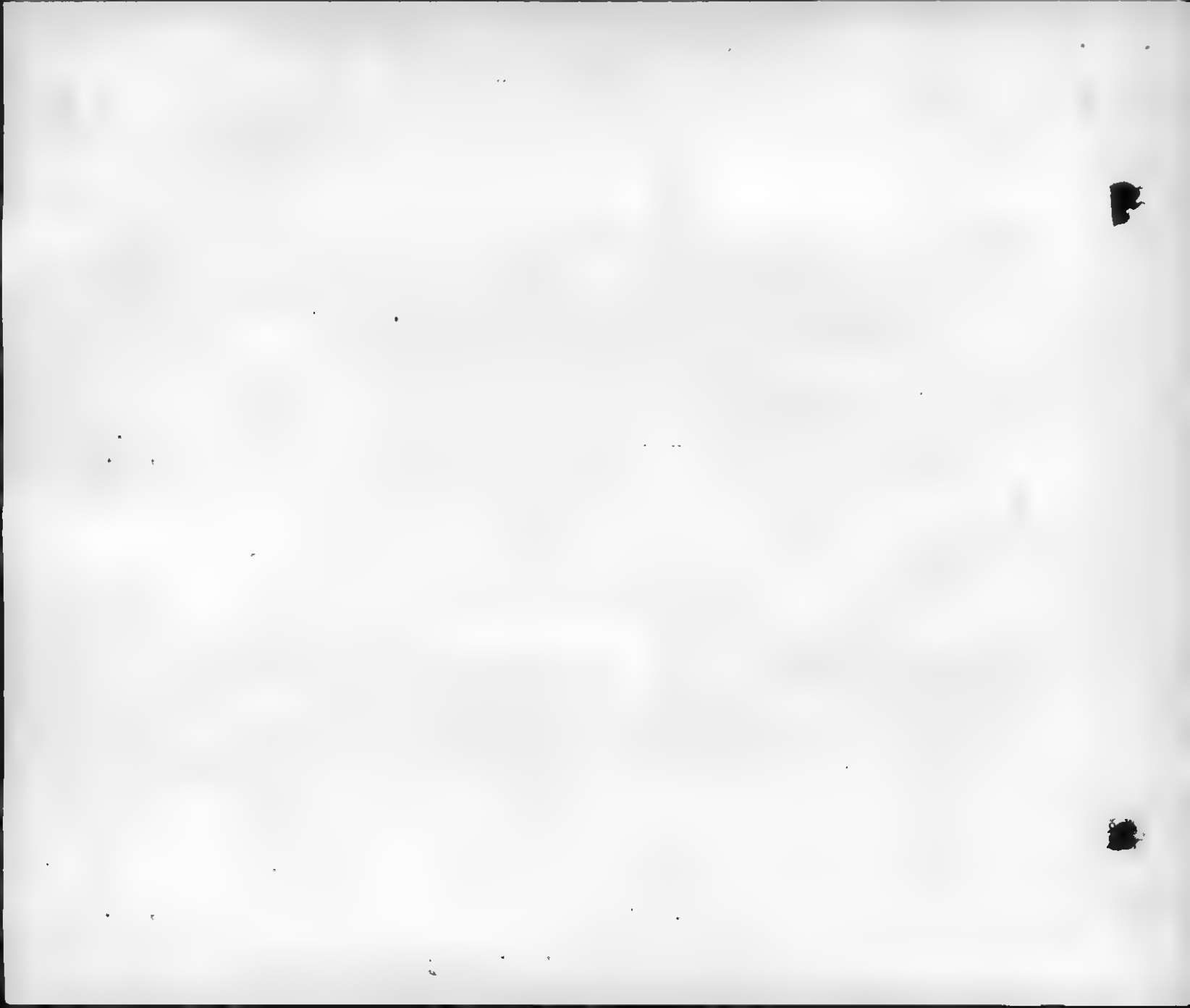
10380

10290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ADELPHI</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sanitarium + Hosp.</u>		d. STREET ADDRESS <u>8113 RIGGS ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>Andrew N M N Pappas</u>		4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-98</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Greece</u>	
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
13. FATHER'S NAME <u>Peter Pappas</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>195-09-4339</u>	
17. INFORMANT <u>John Pappas</u>		Address <u>8113 Riggs Rd. Adelphi, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden cardiac failure</u> DUE TO (b) <u>Cardiac hypertrophy + mitral regurgitation</u> DUE TO (c) <u>Essential hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/5</u> , 19 <u>58</u> , to <u>9/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/8</u> , 19 <u>58</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eino Magi</u> M.D.		ADDRESS (Street, city or town, state) <u>918 University Blvd. East, Silver Spring, Md.</u> DATE SIGNED <u>9/10/58</u>	
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22a. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/12/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond D. Zicka</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			



10400

CERTIFICATE OF DEATH

Reg. Dist. No.

10381

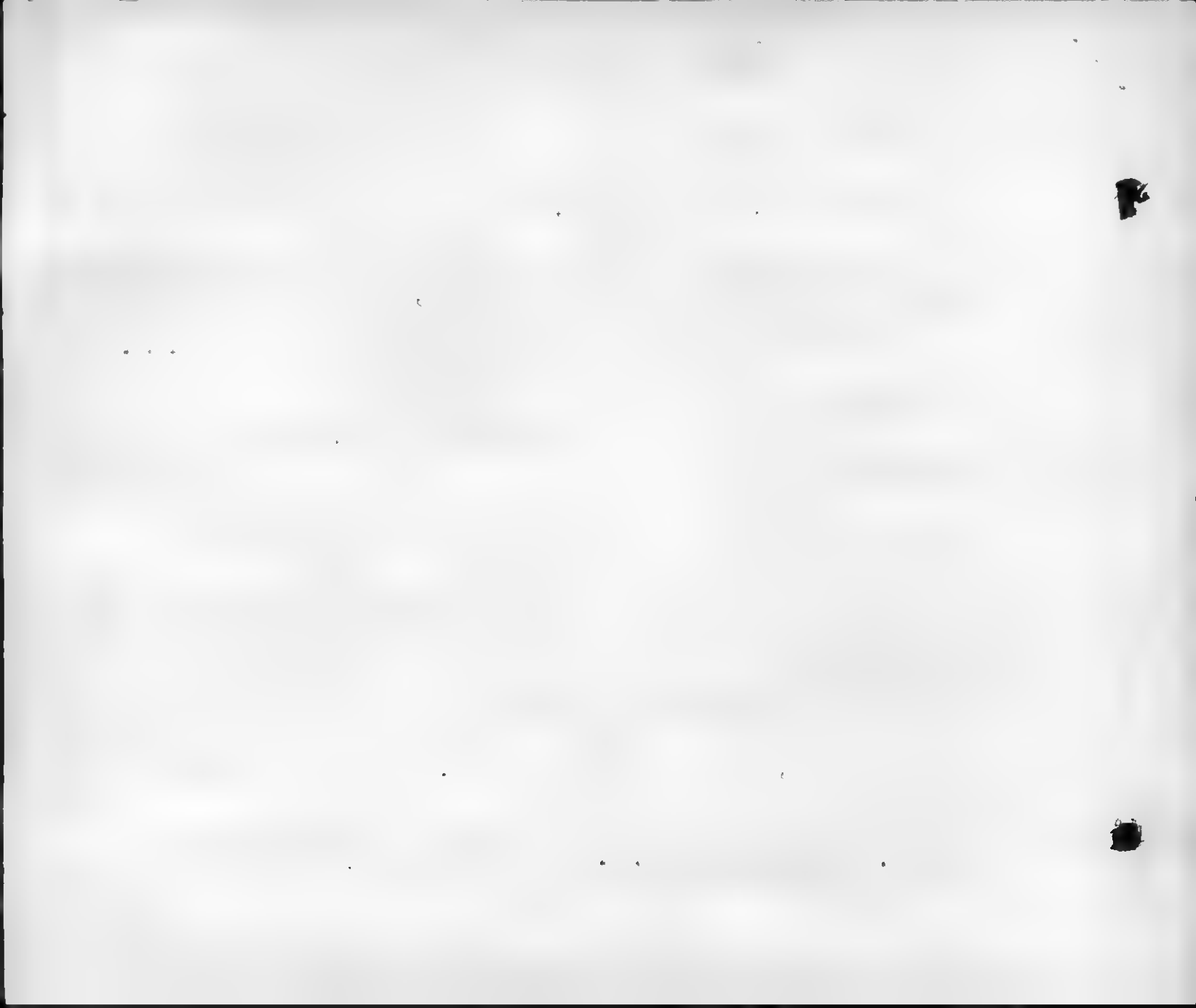
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Union			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1828 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 203 View Avenue			
3. NAME OF DECEASED (Type or print) First Francine Middle (none) Last Pascale				4. DATE OF DEATH Month September Day 4 Year 19 58			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 27, 1932		9. AGE (In years last birthday) yrs 25	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker		10b. KIND OF BUSINESS OR INDUSTRY Office Work		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Pascale				14. MOTHER'S MAIDEN NAME Loretta Pearly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 754.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) postoperative Left subclavian-pulmonary artery anastomosis + aortic valvulotomy (c) Congenital Heart Disease, Tetralogy of Fallot							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from August 17, 19 58 to September 4, 19 58 , that I last saw the deceased alive on September 4, 19 58 , and that death occurred at 3:10 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE N. Perryman Collins				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) N. Perryman Collins, M. D.				DATE SIGNED 9/5/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 9/9/58		22b. DATE THEREOF 9/9/58		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) S. Plainfield, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 9 '58	
				24b. REGISTRAR'S SIGNATURE C. M. L. Frank			

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11540

10401

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>608 Monroe St.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Catherine</u>		4. DATE OF DEATH <u>September 20 1958</u>	
5 SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 20 1958</u>
9. AGE (In years last birthday) <u>6</u>		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emitt Donald Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Veronica Elizabeth Heath</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO <u>176x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-20-58</u> , 19 <u>58</u> , to <u>9-20-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-20-58</u> , 19 <u>58</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Conley</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr. John R. Conley</u>		22. NAME OF CEMETERY OR CREMATORY <u>Suburban Hosp.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hosp.</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>OCT 10 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

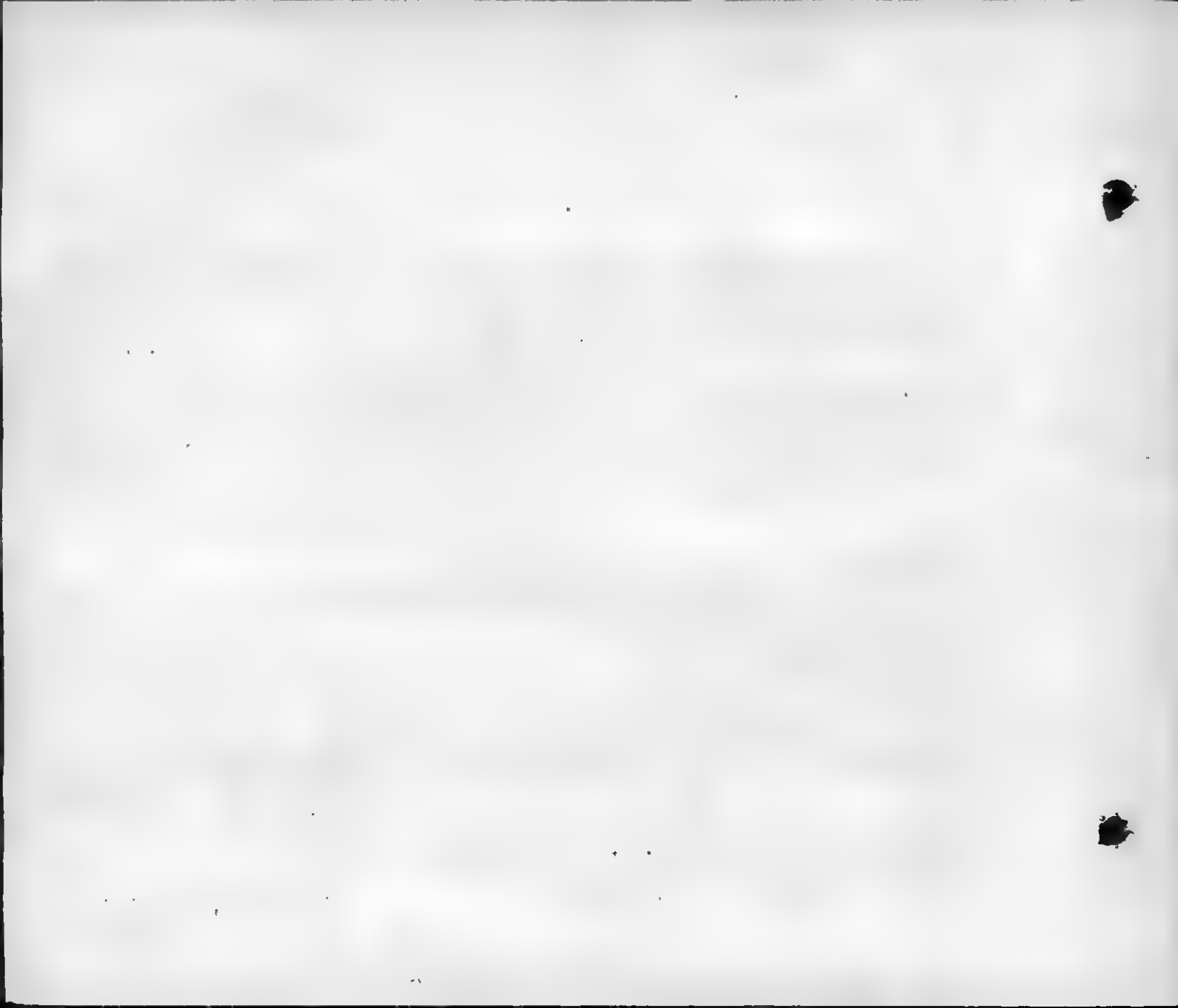
10402

CERTIFICATE OF DEATH

Reg. Dist. No. 10382

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 1318 Chestnut Street							
3. NAME OF DECEASED (Type or print) First Franklin Middle Ray Last Payne				4. DATE OF DEATH Month September Day 16 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1921	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months 3 Days 20 Hours 30 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		11. BIRTHPLACE (State or foreign country) Virginia	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Inmon H. Payne				14. MOTHER'S MAIDEN NAME Goldie Stickles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no		16. SOCIAL SECURITY NO 231-12-9548		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) Rheumatic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible Laennec's Cirrhosis INTERVAL BETWEEN ONSET AND DEATH 3-4 months 4 months ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from September 3, 1958 , to September 16, 1958 , that I last saw the deceased alive on September 16, 1958 , and that death occurred at 2:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/16/58							
ACTUAL SIGNATURE Jean Donald Wilson M.D.				PHYSICIAN'S NAME (Type) Jean Donald Wilson, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-19-58		22c. NAME OF CEMETERY OR CREMATORY Hillsboro	
22d. LOCATION (City, town, or county) Hillsboro, Virginia				22e. (State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Money + King Funeral Home				ADDRESS 171 Maple Ave. W. Vienna, Va		24a. REC'D BY REGISTRAR DATE SEP 19 58	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2, b, should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

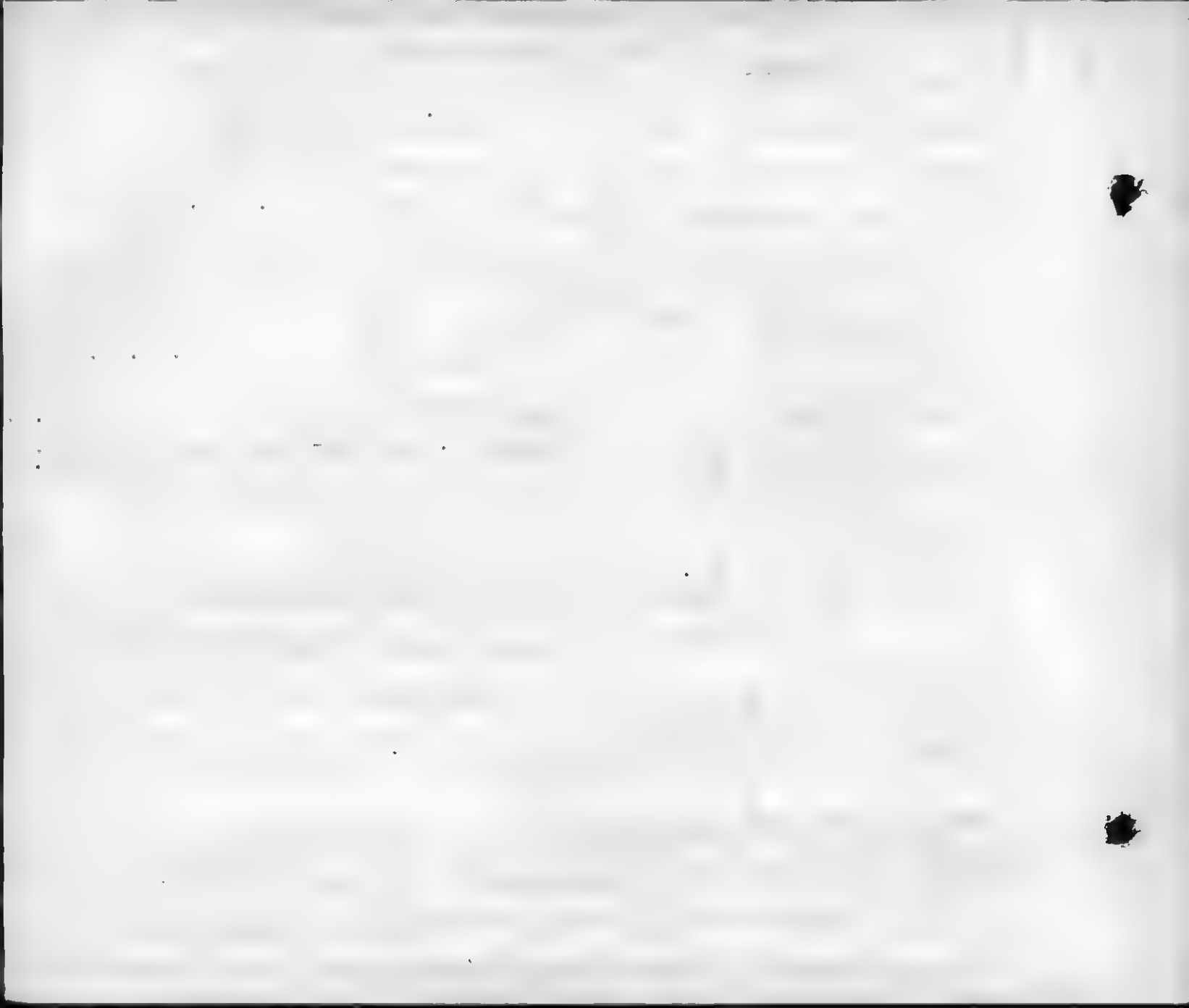
10403

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium				d. STREET ADDRESS 5226 MacArthur Blvd. N.W.			
3. NAME OF DECEASED (Type or print) First BEULAH Middle Last FENDILL				4. DATE OF DEATH Month SEPT Day 26 Year 1958			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1885		9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Raymond Rogers			14. MOTHER'S MAIDEN NAME Ruby Shedd				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Vivian M. Struble-5226 MacArthur Blvd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE HEART DISEASE DUE TO (c) ESSENTIAL HYPERTENSION							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PERICARDITIS WITH EFFUSION							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 3 1958 to SEPT. 26, 1958 , that I last saw the deceased alive on SEPT. 26, 1958 , and that death occurred at 14 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Henry Fendill</i> M.D.				ADDRESS (Street, city or town, state) 5206 NORWAY DR NW			
PHYSICIAN'S NAME (Type) CHEVY CHASE, MD				DATE SIGNED SEP 29 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/27/58	22c. NAME OF CEMETERY OR CREMATORY Burlington Cemetery		22d. LOCATION (City, town, or county) (State) Burlington, Michigan		
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.A. Pine Co.</i>				ADDRESS 2801-14th St. NW Wash DC		24a. REC'D BY REGISTRAR SEP 29 1958	
				24b. REGISTRAR'S SIGNATURE <i>Clara E. Harris</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10404

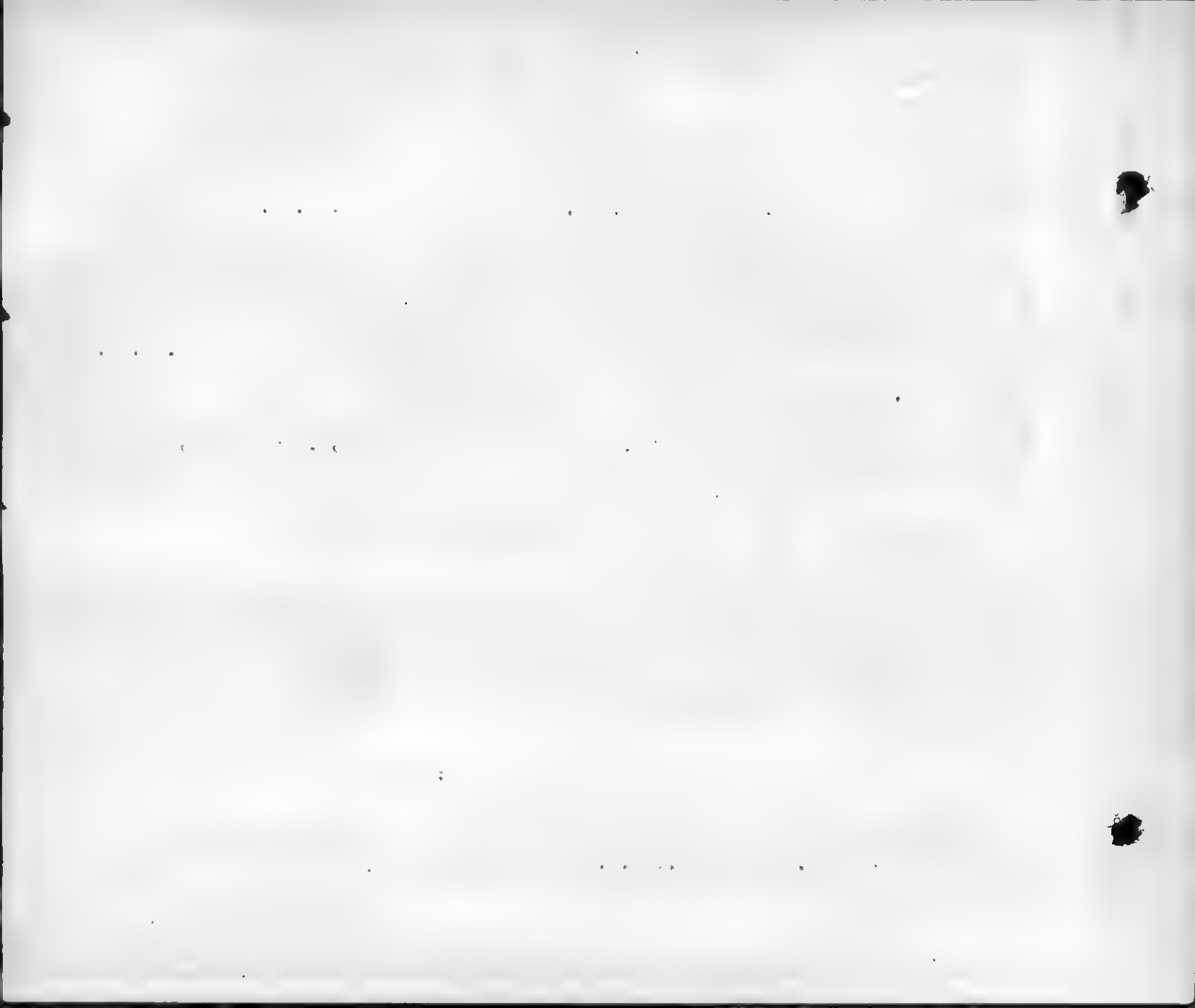
CERTIFICATE OF DEATH

10384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 38 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sadie Middle Mae Last Phillips				4. DATE OF DEATH Month September Day 4 Year 1958			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 22, 1922	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10b. KIND OF BUSINESS OR INDUSTRY Upholstering		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME George W. Phillips				14. MOTHER'S MAIDEN NAME Lena Murphy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 242-34-0196		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE							
DUE TO (b) AORTIC INSUFFICIENCY							
DUE TO (c) MARFAN'S SYNDROME							36 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 28, 1958 to September 4, 1958 , that I last saw the deceased alive on September 4, 1958 , and that death occurred at 5:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Oates, Jr., M.D. M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/5/58			
PHYSICIAN'S NAME (Type) John A. Oates, Jr., M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-7-58		22c. NAME OF CEMETERY OR CREMATORY Church	
22d. LOCATION (City, town, or county) Rocky, N.C.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. R. Bacon ADDRESS 1722 7th St NW				24a. REC'D BY REGISTRAR SEP 8 '58		24b. REGISTRAR'S SIGNATURE C. T. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

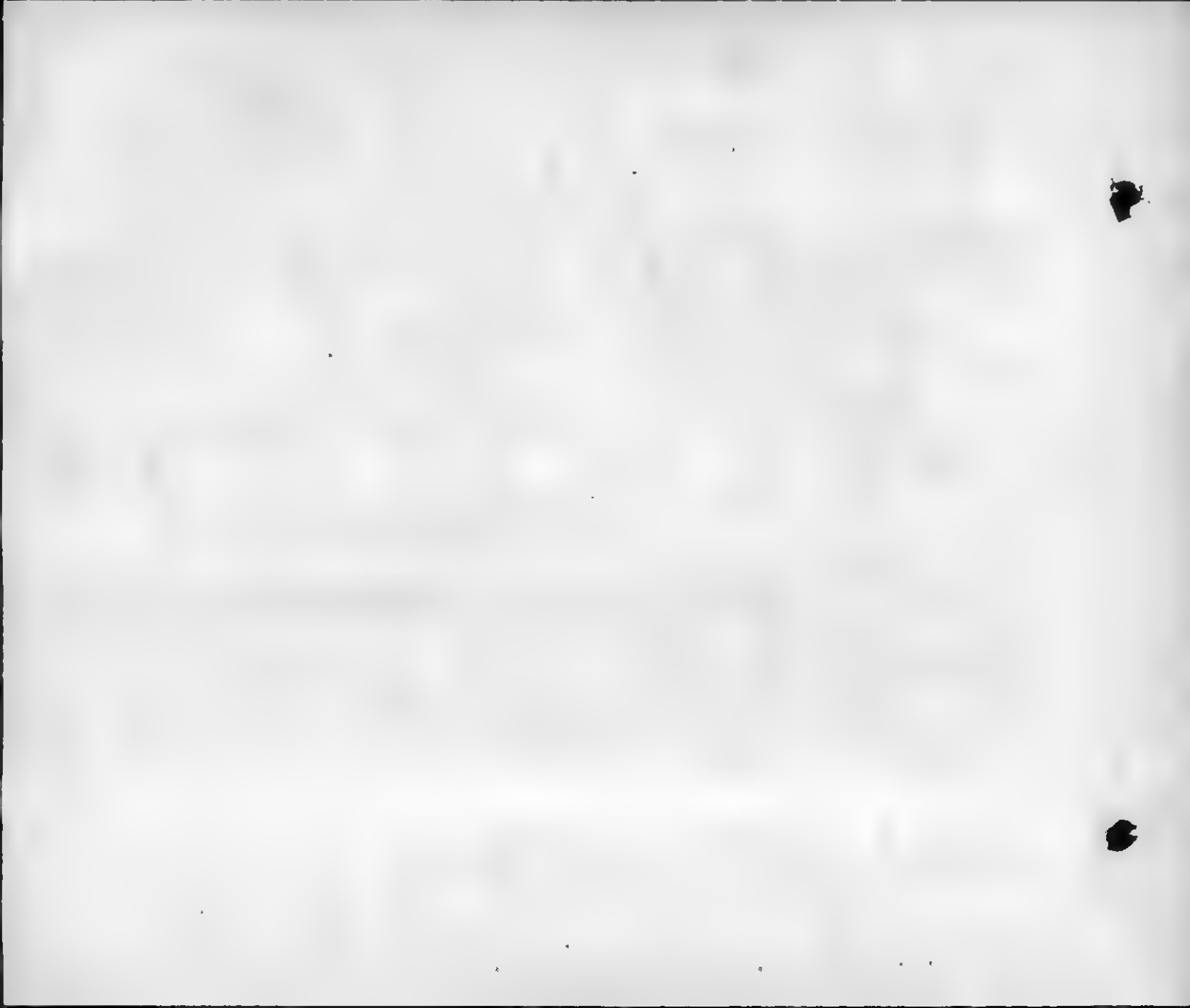
10405

CERTIFICATE OF DEATH

10385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5123 Worthington Dr.</u>		c. LENGTH OF STAY IN 1b <u>Chevy Chase, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>5123 Worthington Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Edna Pindell</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/88</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Stephens</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Beecher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William Hamilton Pindell same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Has been in chronic failure since Dec. 1956</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 26, 1947</u> to <u>today</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-12-</u> 19 <u>58</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>C. P. Ryland</u> M.D. <u>9-12-58</u> <u>4100 - 49th St., N. W.</u> <u>Washington 16, D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>9/12/58</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10386

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c LENGTH OF STAY IN 1b D. O. A. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE Maryland b. COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's d. STREET ADDRESS Bucklarge Rd.	
3. NAME OF DECEASED (Type or print) Phyllis Victoria Plummer		4. DATE OF DEATH September 4 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH Oct 7-57	9. AGE (in years last birthday) 10 IF UNDER 1 YEAR 27 IF UNDER 24 HRS 10 Months 27 Days 27 Hours 27 Min.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY ind	
11 BIRTHPLACE (State or foreign country) ind		12. CITIZEN OF WHAT COUNTRY? MSA	
13. FATHER'S NAME Carroll William Plummer		14. MOTHER'S MAIDEN NAME Della Virginia Simms	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Nella V. Plummer - Boyd's, ind		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Metastasis, Bilateral 4 DUE TO Aspiration Gastric Contents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Interstital Pneumonia (b) Interstital Pneumonia (c) Interstital Pneumonia		INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Brochart		DATE SIGNED 9-4-58	
EXAMINER'S NAME (Type) FRANK J. Brochart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-6-58	
22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Boyd, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert R. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR SEP 8 1958		24b. REGISTRAR'S SIGNATURE SEP 8 1958	



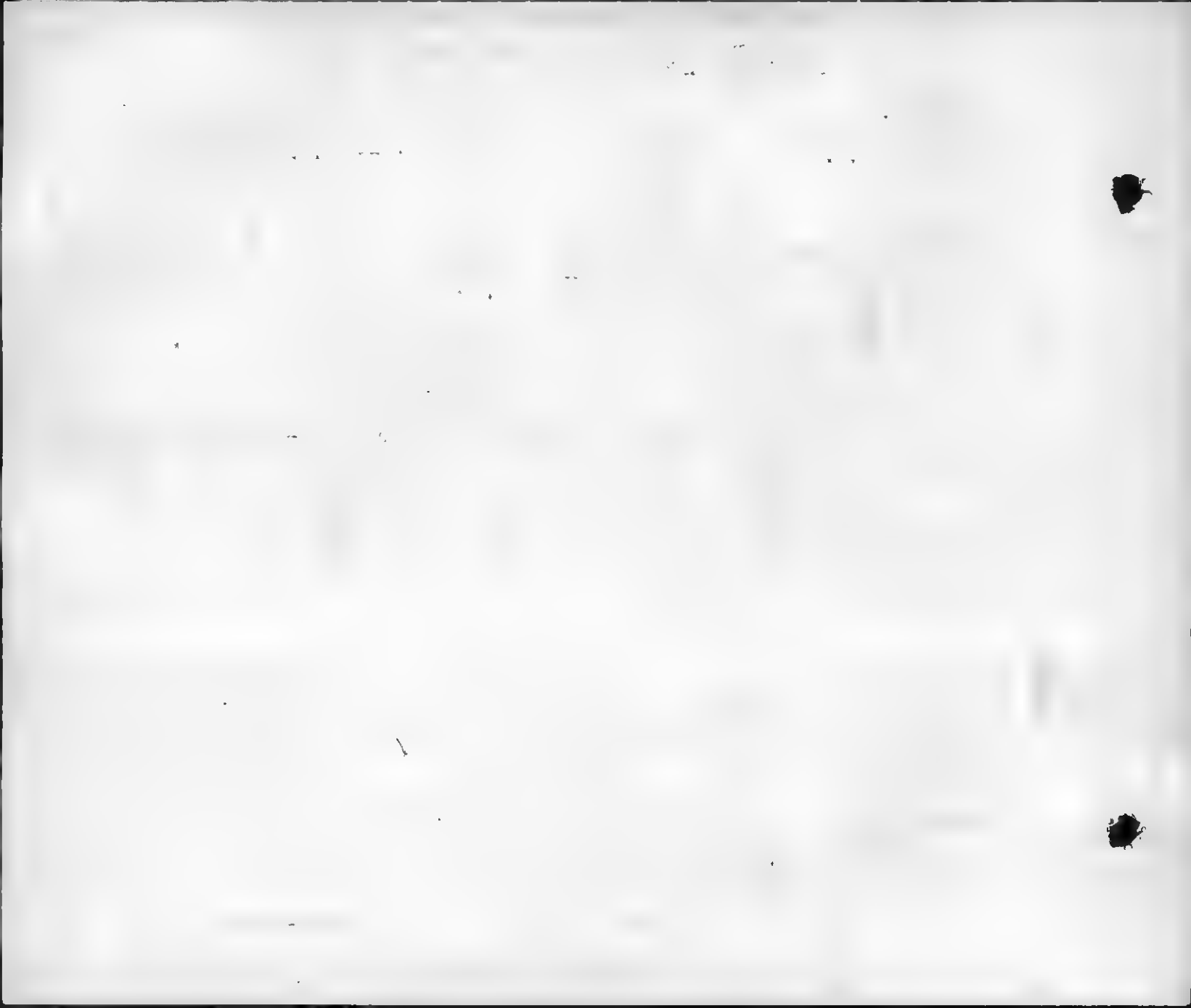
10407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd R.F.D. c. LENGTH OF STAY IN 1b 2 dya d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson---R.F.D # 1 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle Elizabeth Last Poston		4. DATE OF DEATH Month Sept Day 13 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27-1872
9. AGE (In years birth day) 86		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Poston		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Phillis Ningrad		Address 3109-Parkway, Baltimore, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 48 hours 2 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 1957 to 13 Sept. 1958 , that I last saw the deceased alive on 12 Sept 1958 , and that death occurred at 6:15 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) BARNESVILLE, MD DATE SIGNED 14 Sept 58			
ACTUAL SIGNATURE Gordon M. Smith		M.D. BARNESVILLE, MD	
PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 16-58	22c. NAME OF CEMETERY OR CREMATORY Greenville	22d. LOCATION (City, town, or county) (State) Berryville, Va
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Shelton		ADDRESS Barnesville, Md.	24a. REC'D BY REGISTRAR SEP 16 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

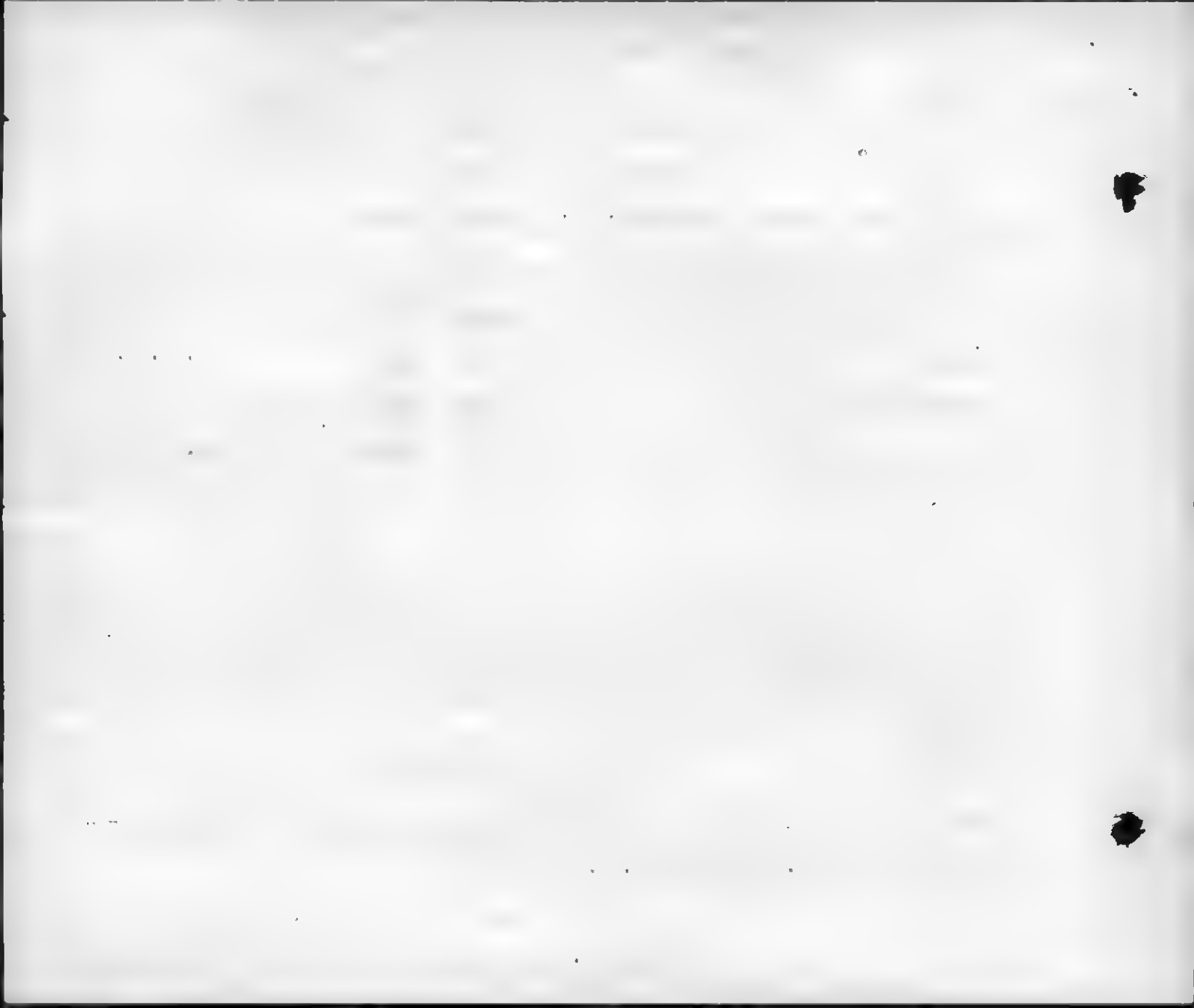
10408

CERTIFICATE OF DEATH

Reg. Dist. No. 10388

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 119 days		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY Tazewell		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Amonate		d. STREET ADDRESS (none)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eddie Middle Dean Last Powers		4. DATE OF DEATH Month September Day 1 Year 1958		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 2, 1955		9. AGE (In years last birthday) 2 yrs 11 Months 27 Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charlie Powers		14. MOTHER'S MAIDEN NAME Lodina Beavers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 104.3 DUE TO purulent meningitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1191 DUE TO acute lymphocytic leukemia (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) bronchopneumonia; gastrointestinal hemorrhage INTERVAL BETWEEN ONSET AND DEATH 17 mos.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 5 , 1958, to September 1 , 1958, that I last saw the deceased alive on September 1 , 1958, and that death occurred at 12:05 A.M. , from the causes and on the date stated above.													
ACTUAL SIGNATURE Harold R Silberman		M.D. The Clinical Center		ADDRESS (Street, city or town, state) The National Institutes of Health		DATE SIGNED 9-1-58		PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.		Address Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/2/58		22c. NAME OF CEMETERY OR CREMATORY Powers Cemetery		22d. LOCATION (City, town, or county) (State) Amonate, Virginia		23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS 			
24a. REC'D BY REGISTRAR DATE SEP 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10389

10409

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia				b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN b 45 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencer				✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 113 Cross Street, Box 224				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Carol Jean Propps				4. DATE OF DEATH Month Day Year September 21, 1958											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1945		9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 74 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Nebraska				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Ernest L. Propps				14. MOTHER'S MAIDEN NAME Irma Engel											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute lymphocytic leukemia</i> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH 15 Mths			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 7, 1958, to September 21, 1958, that I last saw the deceased alive on September 21, 1958, and that death occurred at 1:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 9/21/58 National Institutes of Health Bethesda 14, Maryland															
ACTUAL SIGNATURE <i>James M. Marsh</i>				M.D. James M. Marsh, M.D.											
PHYSICIAN'S NAME (Type)															
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 9/24/58				22c. NAME OF CEMETERY OR CREMATORY —				22d. LOCATION (City, town, or county) (State) Spencer, W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 1400 Chapin St NW Washington				24b. REG'D BY REGISTRAR SEP 24 '58 DATE				24a. REGISTRAR'S SIGNATURE Arthur S. Kraw			



1

10410

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10390

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12013 Grandview Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Pauline Rao Puglisi</u>				4. DATE OF DEATH Month Day Year <u>Sept 15 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 14, 1899</u>	9. AGE (In years last birthday) yrs. <u>59</u>	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furs</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Lorenzo Rao</u>				14. MOTHER'S MAIDEN NAME <u>Grace Puglisi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-18-4588</u>		17. INFORMANT Address <u>Pasquale Puglisi 12013 Grandview Ave. Silver Spring, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor - Metastatic</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral carcinoma of the breast</u> DUE TO (c) <u>8 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1950</u> , 19 <u>50</u> , to <u>Sept 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>58</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2100 Conn. Ave., N.W., Wash. D.C.</u> <u>9/15/58</u>							
ACTUAL SIGNATURE <u>Eugene A. Forcione</u> M.D.							
PHYSICIAN'S NAME (Type) <u>EUGENE A. FORCIONE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		22b. DATE THEREOF <u>9/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN MAUSOLEUM</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Raymond A. Ziska, SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 18 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10391**

10411

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8434 GEORGIA AVENUE		e. STREET ADDRESS 1600 EAST WEST HIGHWAY	
3. NAME OF DECEASED (Type or print) WARNER EDWARD PUMPHREY		4. DATE OF DEATH Month SEPTEMBER Day 7 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) funeral director		10b. KIND OF BUSINESS OR INDUSTRY funeral	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM REUBEN PUMPHREY		14. MOTHER'S MAIDEN NAME HARRIET A. Shekell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW #1		16. SOCIAL SECURITY NO 218-24-3291	
17. INFORMANT Edna C. Pumphrey, 1600 East-West Highway, SS., Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) sudden DUE TO (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/10/58	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE SEP 9 58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the "Certificate" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10412

CERTIFICATE OF DEATH

Reg. Dist. No. 215

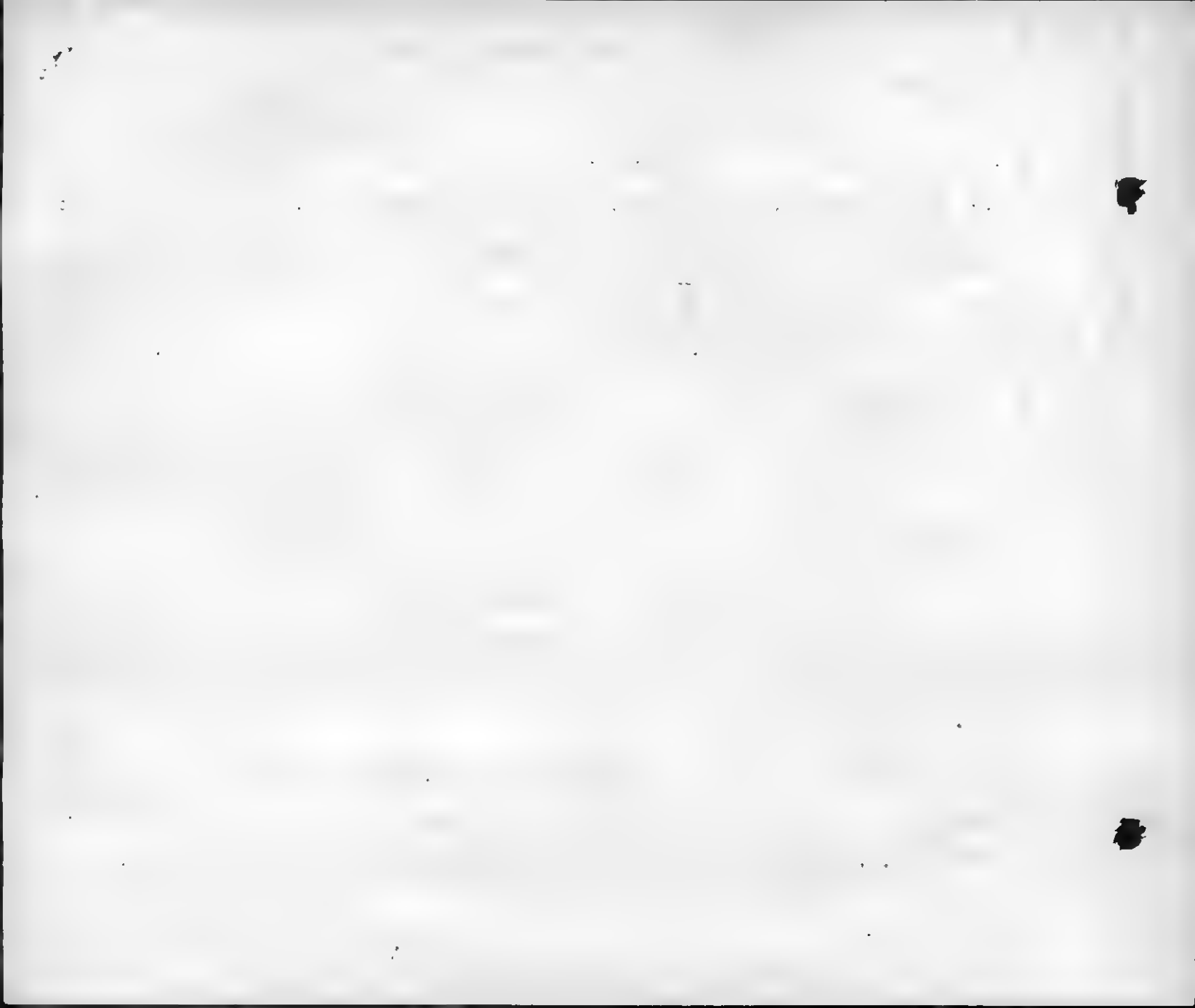
10392

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 mos. 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Emil Last QUENSTEDT				4. DATE OF DEATH Month September Day 10 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 March 1890	9. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Quenstedt				14. MOTHER'S MAIDEN NAME Alberta Crouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I Unknown		17. INFORMANT (Wife) Mrs. May L. Quenstedt (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung with Metastases 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH About 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 June , 19 58 , to 10 Sept. , 19 58 , that I last saw the deceased alive on 10 Sept. , 19 58 , and that death occurred at 12:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. U. Shilling U.S. Naval Hospital, Bethesda, Md. 9-10-58							
ACTUAL SIGNATURE C. U. SHILLING, LT, MC, USN				PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-15-58		22c. NAME OF CEMETERY OR CREMATORY Academy Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. M. Taylor, 147 Gloucester St. Annapolis, Md.				24a. REC'D BY REGISTRAR SEP 19 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville R.F.D.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty Co. Gen Hosp</u>		e. STREET ADDRESS <u>Unity Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Ralph A. Reese</u>		4. DATE OF DEATH <u>Sept 1 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 9 1934</u>
9. AGE (In years last birthday) <u>23</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>gas station</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vilbert Reese</u>		14. MOTHER'S MAIDEN NAME <u>Nancy McDaniel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Estelle Reese</u>		Address <u>R-2 Gaithersburg md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>drowning</u> (a), stating the underlying cause last. (c) <u>auto accident</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was driven from that massed bridge & overturned in Potomac R.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>Sept 1 1958</u> Hour <u>5:30</u> P.M.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>md R-97</u>	20f. (City or town) <u>N. Sunshine Monty</u> (County) <u>md</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>9-1-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Liberty Baptist</u>	22d. LOCATION (City, town, or county) <u>Lisbon, Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>		ADDRESS <u>Laytonville, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	
DATE <u>SEP 5 1958</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10291

CERTIFICATE OF DEATH

Reg. Dist. No.

10394

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 259 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON				4. DATE OF DEATH Month SEPTEMBER Day 29 Year 1958			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL				d. STREET ADDRESS 4216 YUMA ST., N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle DEE Last RICHARDSON							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-14-00	
9. AGE (In years lost birthday) 58 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Information Sp.		11. BIRTHPLACE (State or foreign country) Oregon		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME James Green Richardson				14. MOTHER'S MAIDEN NAME Maudie Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chart Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 401 Broncho Pneumonia				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/14 , 19 58 , to September 29 , 19 58 , that I last saw the deceased alive on September 29 , 19 58 , and that death occurred at 3⁰⁷ A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1216 16th St. N.W. Wash. D.C. DATE SIGNED 9/30/58							
ACTUAL SIGNATURE Albert E. Marland, Jr. M.D.							
PHYSICIAN'S NAME (Type) Albert E Marland, Jr.				1216 16th St. N.W. Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/2/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert T. Thompson				24a. REC'D BY REGISTRAR DATE OCT 2 '58		24b. REGISTRAR'S SIGNATURE J. L. [unclear]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10292

CERTIFICATE OF DEATH

10396

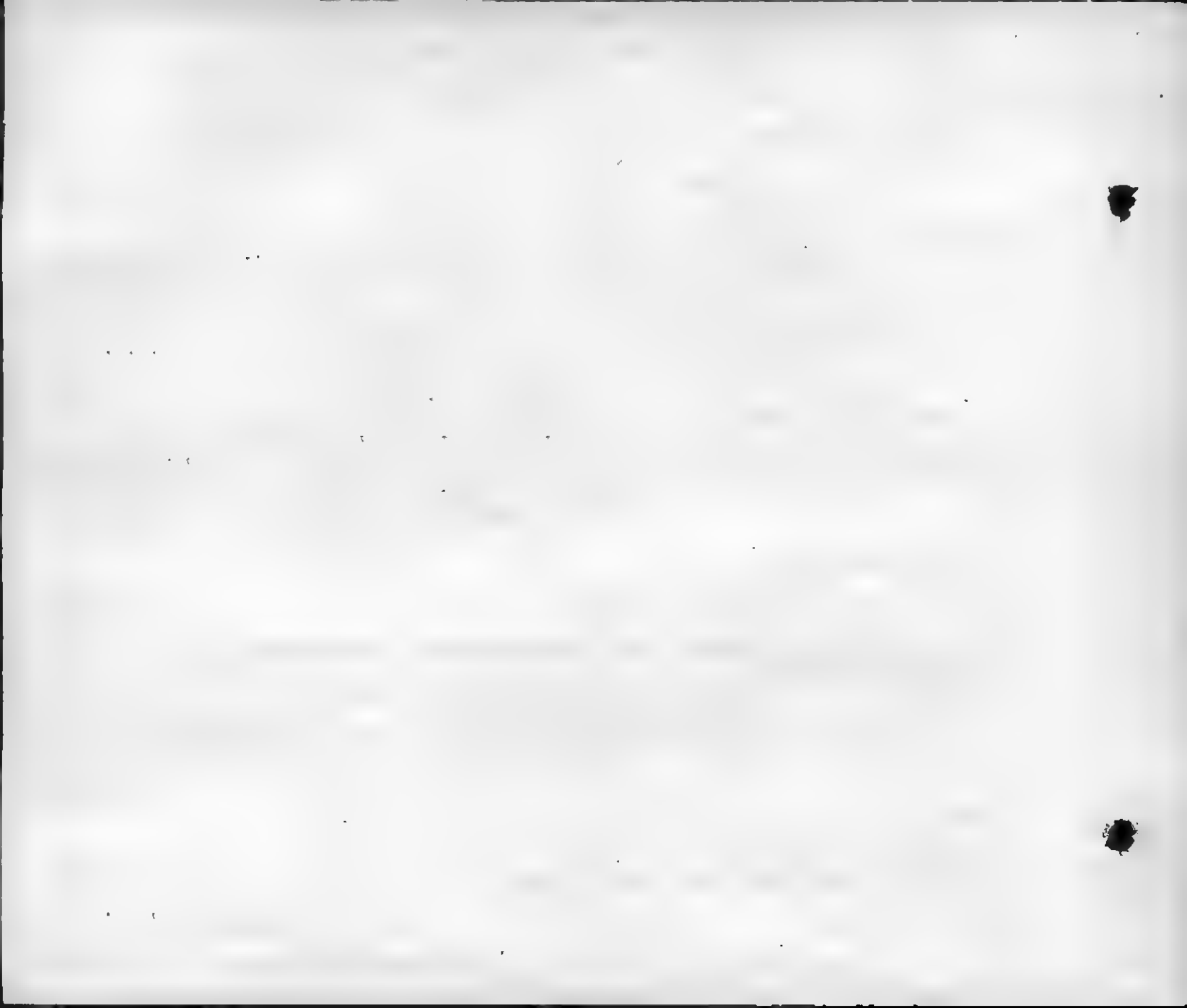
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 5 1/2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 ALBANY AVENUE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
		d. STREET ADDRESS 711 ORCHARD WAY	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST ANNIE BURCH RILEY		4. DATE OF DEATH Month SEPT. Day 15 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/76
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME G. MORTIMER CECIL		14. MOTHER'S MAIDEN NAME SARAH J. BURCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Edgar L. Burch, 711 Orchard Way Silver Spring, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease - 4 years. (c) Arteriosclerosis & Hypertension - 7 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>april</u> , 1954, to <u>Sept 15</u> , 1958, that I last saw the deceased alive on <u>Sept 13</u> , 1958, and that death occurred at <u>12:57 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm P. Campbell</u>		ADDRESS (Street, city or town, state) <u>Kenerson Apt.</u>	
PHYSICIAN'S NAME (Type) <u>Neil P. Campbell</u>		DATE SIGNED <u>9/15/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/18/58	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE <u>SEP 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

10414

CERTIFICATE OF DEATH

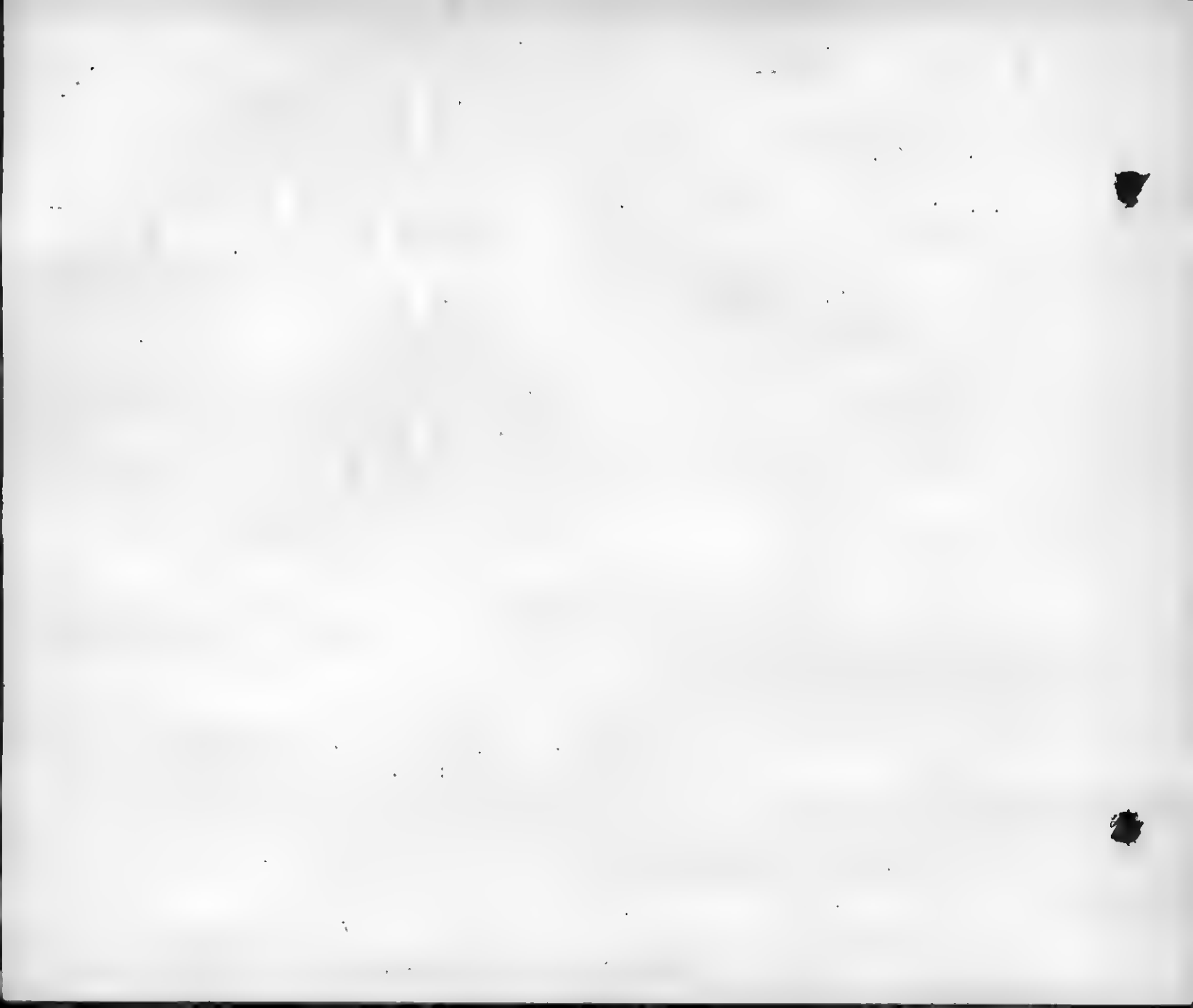
Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 541 Belleview Drive			
3. NAME OF DECEASED (Type or print) First Donald Middle Dennis Last ROSCH				4. DATE OF DEATH Month Sept. Day 19 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 Sept. 1958	
9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR Months 6 Days 6 Hours 6 Min.		IF UNDER 24 HRS Months 6 Days 6 Hours 6 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Leon ROSCH				14. MOTHER'S MAIDEN NAME Jeanne Evelyn MAC LELLAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO None		17. INFORMANT (Father) Leon ROSCH (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteraemia organism E. coli 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiple congenital anomalies DUE TO (c) 6 days				INTERVAL BETWEEN ONSET AND DEATH 6 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 13 Sept. , 19 58 , to 19 Sept. , 19 58 , that I last saw the deceased alive on 19 Sept. , 19 58 , and that death occurred at 11:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED							
ACTUAL SIGNATURE Bethesda per Dr. Harris				PHYSICIAN'S NAME (Type) F. De PAOLA LT MC USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 9-23-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l CEMETERY	
22d. LOCATION (City, town, or county) (State) Arlington Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE ARLINGTON Funeral Home				24a. REC'D BY REGISTRAR SEP 23 '58		24b. REGISTRAR'S SIGNATURE Wm. S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1051352 XV



CERTIFICATE OF DEATH

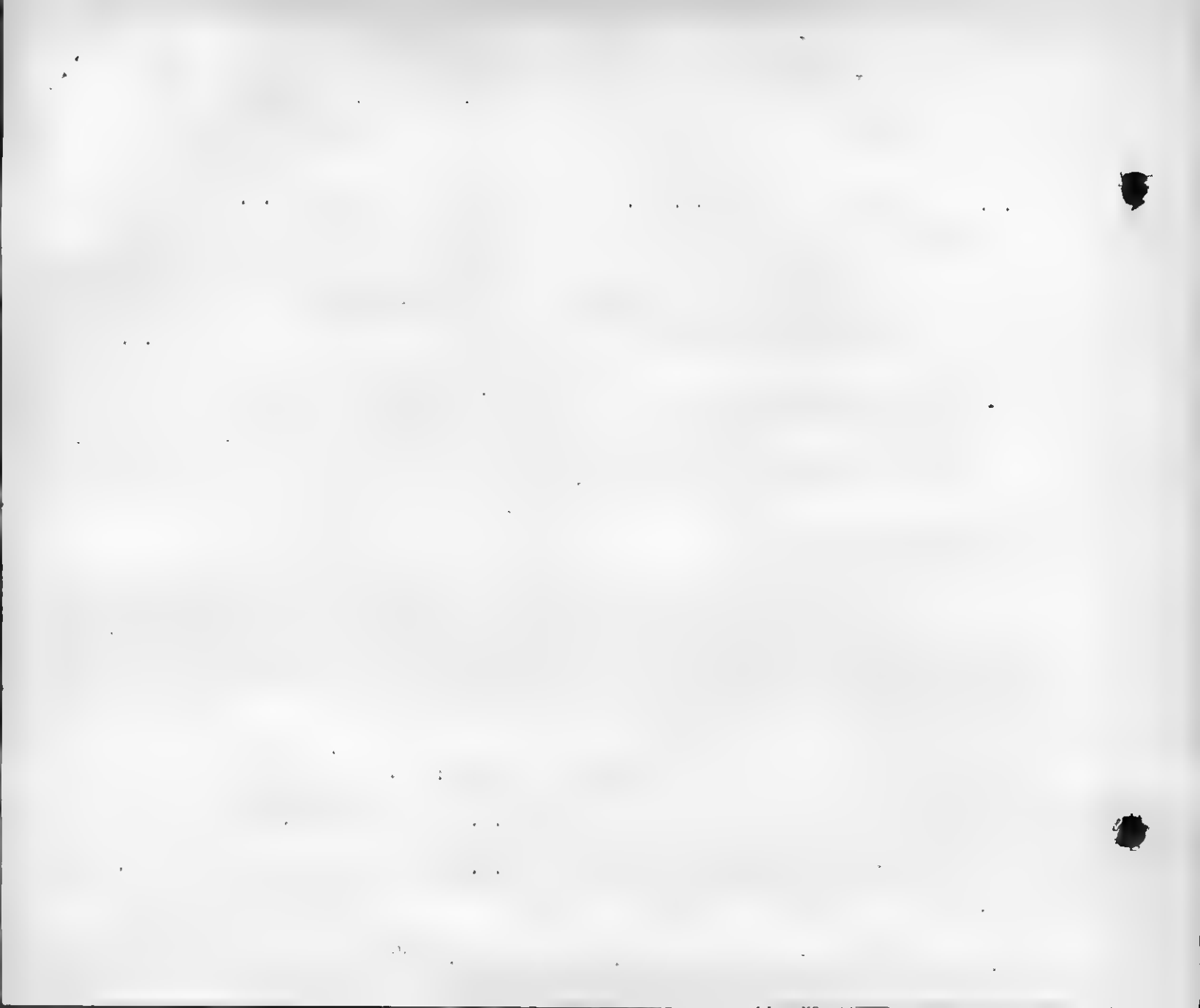
Reg. Dist. No. 215

10415

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an: Residence before admiss an) a. STATE District of Columbia D. C. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1606 "W" Street, S.E.	
e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Betty Middle Mae Last SARGENT		4. DATE OF DEATH Month September Day 17 Year 19 58	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 November 1937
9. AGE (In years last birthday) yrs 20		IF UNDER 1 YEAR Months 20 Days 20 Hours 20 Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Johnny Freeman BENTON		14. MOTHER'S MAIDEN NAME Mary Elizabeth LASTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT (Husband) Richard John SARGENT (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pyelonephritis with abscess formation and papillary necrosis, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 August 19 58 to 17 Sept. 19 58 , that I last saw the deceased alive on 17 Sept. 19 58 , and that death occurred at 9:26 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C.R. Boyce		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
DATE SIGNED 9-18-58			
PHYSICIAN'S NAME (Type) C.R. BOYCE, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-58	
22c. NAME OF CEMETERY OR CREMATORY Weldon Cemetery		22d. LOCATION (City, town, or county) (State) Weldon, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	
24a. REC'D BY REGISTRAR SEP 23 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

10416

CERTIFICATE OF DEATH

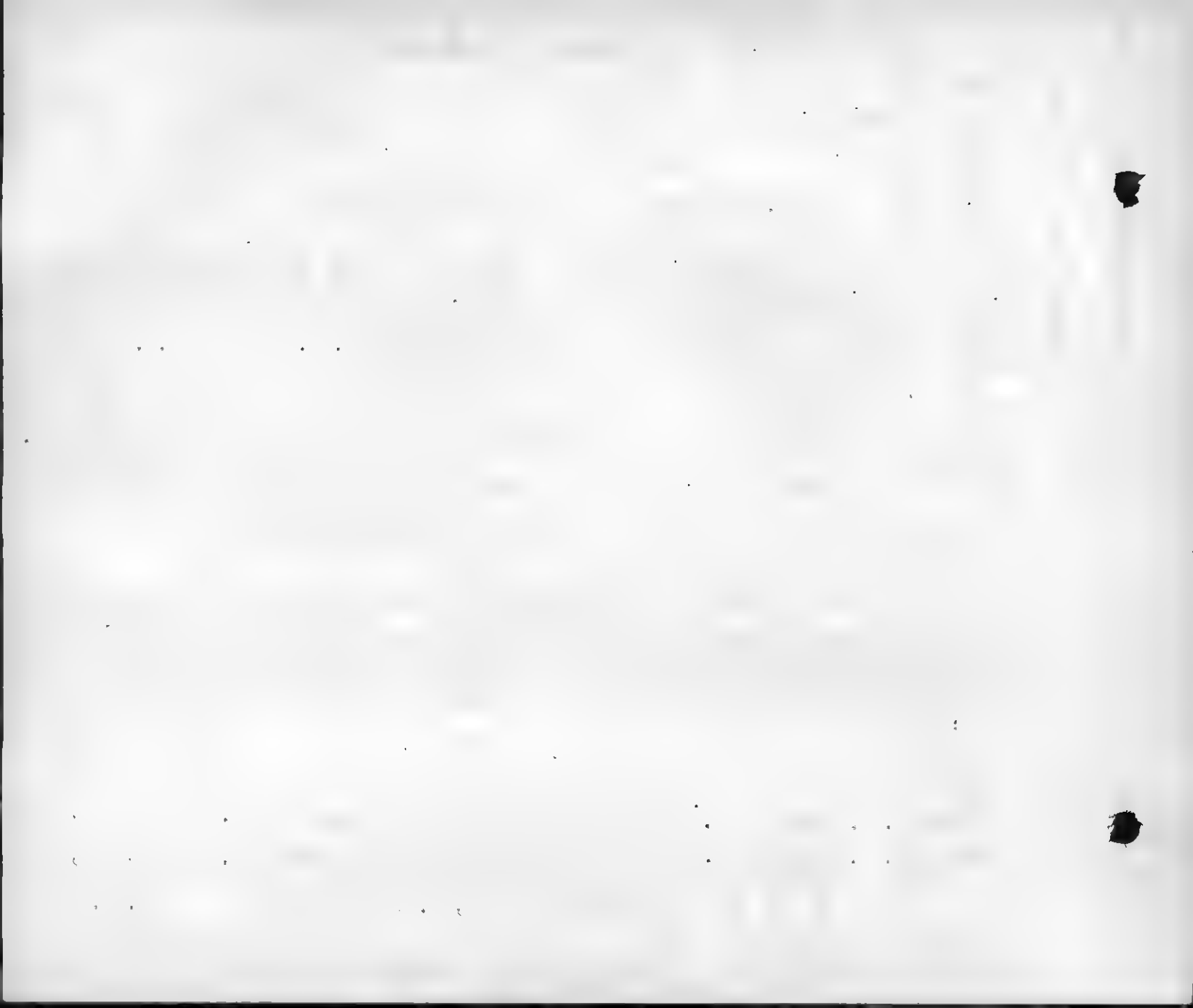
10399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville							
c. LENGTH OF STAY IN 1b 42 days		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH NMC Bethesda, Maryland							
d. STREET ADDRESS Rockville Pike		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Emma Middle Elizabeth Last SCHMULOVITZ		4. DATE OF DEATH Month September Day 6 Year 19 58							
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVIDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1877						
9. AGE (In years last birthday) 80 yrs <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days	Hours	Min	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
IF UNDER 1 YEAR	IF UNDER 24 HRS								
Months	Days								
Hours	Min								
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Washington, D. C.							
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOHN F. TALBERT							
14. MOTHER'S MAIDEN NAME ANNIE GENGRODT A. J. Gengrodt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No							
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MRS JOSEPHINE GELFO 6524 8th Ave Ray Park, Md.							

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Cerebral Vascular Accidents 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Peripheral Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Jul 27, 1958	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma, Breast with Metastasis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 6:55 p. m. Sep 6 19 58	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
(State)		21. I certify that I attended the deceased from Jul 27, 19 58 to Sep 6, 19 58 , that I last saw the deceased alive on Sep 6, 19 58 , and that death occurred at 1855P , from the causes and on the date stated above.	
ACTUAL SIGNATURE W. J. JACOBY, Jr.		ADDRESS (Street, city or town, state) USNH, NMC, Bethesda, Md.	
PHYSICIAN'S NAME (Type) W. J. JACOBY Jr.		DATE SIGNED Sep 7, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF Sep 19, 1958		22c. NAME OF CEMETERY OR CREMATORY Congressional Wash., D.C.	
22d. LOCATION (City, town, or county) Washington, D. C.		24a. REC'D BY REGISTRAR DATE 10 58	
24b. REGISTRAR'S SIGNATURE C. E. Kneeb		24c. REGISTRAR'S SIGNATURE C. E. Kneeb	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 39 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jasper		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 322 East 15th Street		4. DATE OF DEATH Month September Day 14 Year 19 58		3. NAME OF DECEASED (Type or print) First Edwin Middle Richard Last Schutz		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1919		9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR: Months 39 Days 39 Hours 39 Min 39		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Superintendent		10b. KIND OF BUSINESS OR INDUSTRY City Government	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edward Schutz		14. MOTHER'S MAIDEN NAME Augusta Tretter		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO Unavailable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 173X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Choriocarcinoma with pulmonary metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 Weeks		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastases to brain, liver, thyroid and pancreas		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 6 , 19 58 , to September 14 , 19 58 , that I last saw the deceased alive on September 14 , 19 58 , and that death occurred at 8:00 A. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 9-14-58		ACTUAL SIGNATURE Richard H. Moy		M.D. The National Institutes of Health		PHYSICIAN'S NAME (Type) Richard H. Moy, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 9-14-58		22b. DATE THEREOF 9-14-58		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Dubois County, Indiana		23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans		25. I certify that I attended the deceased from August 6 , 19 58 , to September 14 , 19 58 , that I last saw the deceased alive on September 14 , 19 58 , and that death occurred at 8:00 A. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 9-14-58		ACTUAL SIGNATURE Richard H. Moy	

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10418

CERTIFICATE OF DEATH

10401

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Alabama			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phenix City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route 3, Box 517			
3. NAME OF DECEASED (Type or print) First Middle Last Randolph (none) Scott				4. DATE OF DEATH Month Day Year September 5, 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 14, 1957	
9. AGE (In years last birthday) yrs 21		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Scott				14. MOTHER'S MAIDEN NAME Albertha Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital transverse aortic arch and interventricular septal defect DUE TO (b) Cardiac arrest, post-operative pulmonary artery DUE TO (c) Shock congestion: lungs, liver, spleen, kidneys CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), OR (c), STATING THE UNDERLYING CAUSE LAST.						INTERVAL BETWEEN ONSET AND DEATH since birth 11 hours post op. hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from August 24, 1958, to September 5, 1958, that I last saw the deceased alive on September 5, 1958, and that death occurred at 11:20 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert S. Bloodwell				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) ROBERT S. BLOODWELL, M.D.				DATE SIGNED 9/7/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/11/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Columbus, Ga.	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins Funeral Home				ADDRESS 4804 GA. AVE. N.E.		24a. REC'D BY REGISTRAR SEP 15 '58	
				24b. REGISTRAR'S SIGNATURE Charles S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10402

10298

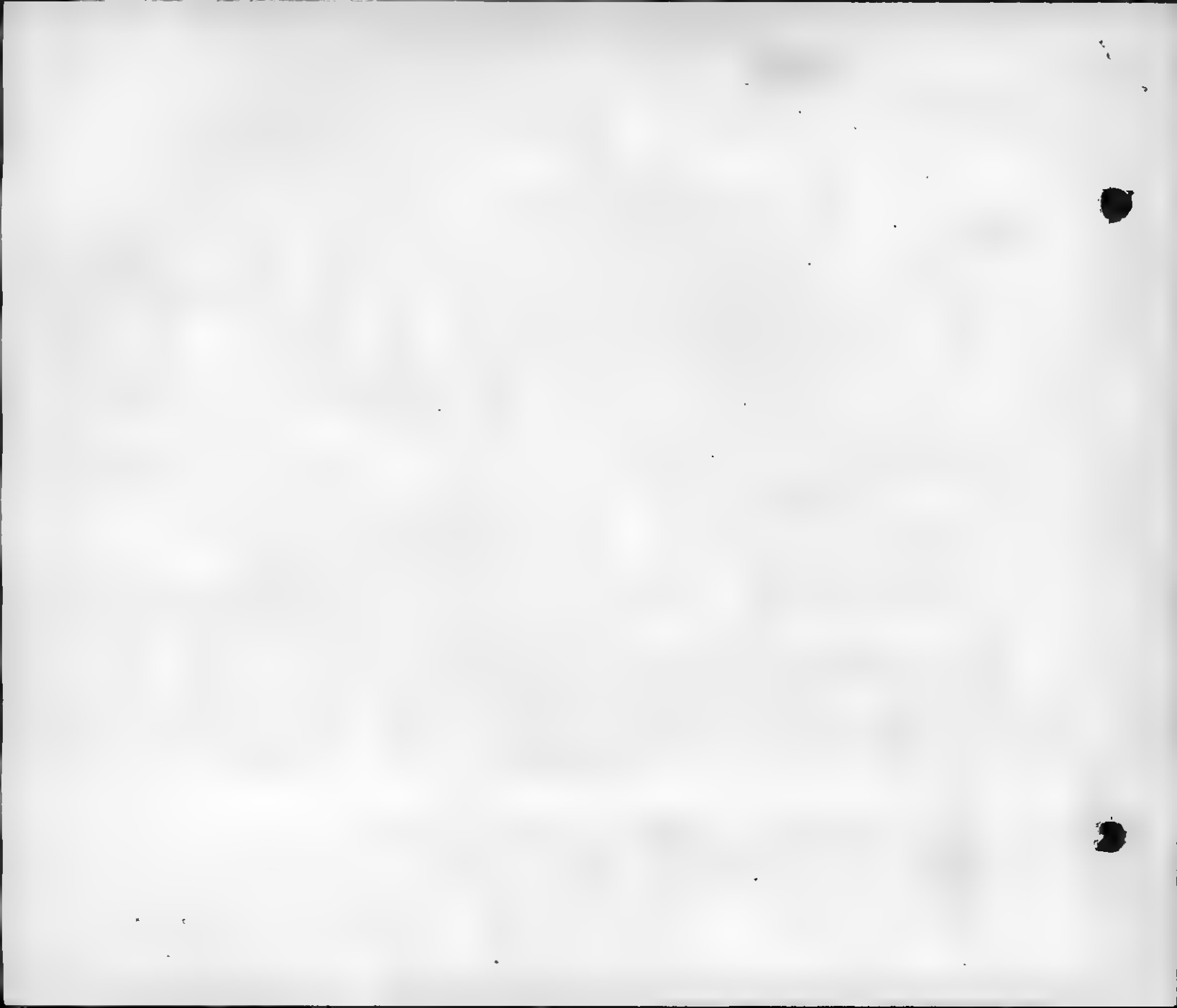
Reg. Dist No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12917 Parkland Dr</u>		e. STREET ADDRESS <u>12917 Parkland Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Antonino Scuderi</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-5-94</u>	
9. AGE (in years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>24</u> Hours <u>19</u> Min <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Car repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retiree</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Scarmelo Scuderi</u>		14. MOTHER'S MAIDEN NAME <u>Rose NUNNIA TRIXILETTI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>718-14-9114</u>	
17. INFORMANT <u>Rose Scuderi</u>		Address <u>Itun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Cardio-vascular disease</u> (c) <u>12 yrs</u> DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Bisca</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. H. H. H.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10419

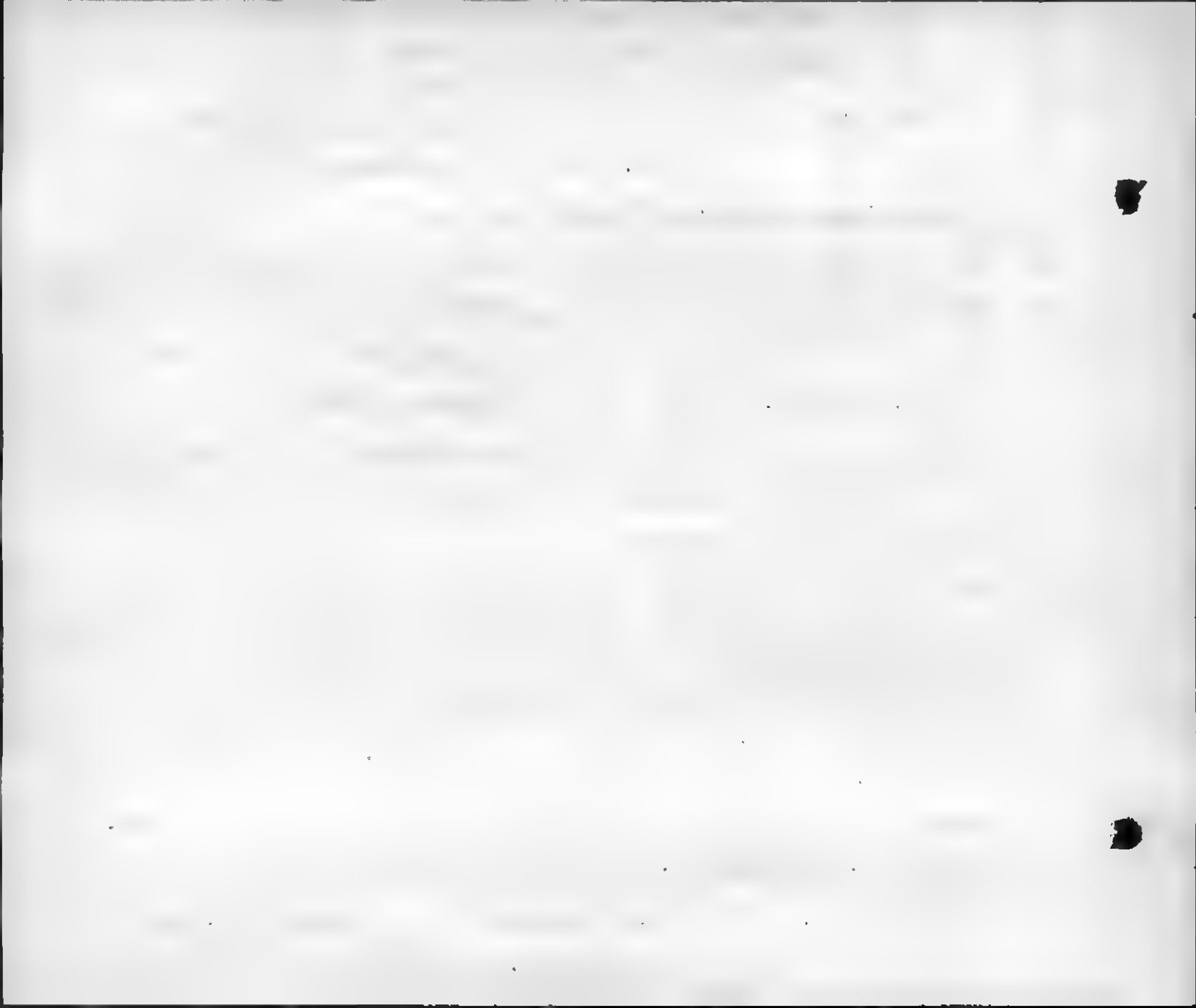
CERTIFICATE OF DEATH

Reg. Dist. No.

10403

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 63 hrs. 23 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS West Friendship			
3. NAME OF DECEASED (Type or print) First Baby Middle - Last Selby				4. DATE OF DEATH Month September Day 5 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/58		9. AGE (In years last birthday) 63	IF UNDER 1 YEAR IF UNDER 24 HRS Months 23 Days 63 Hours 23 Min 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Selby, Sr.				14. MOTHER'S MAIDEN NAME Hilda M. Affeldt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Sept. 3 , 19 58 , to Sept. 5 , 19 58 , that I last saw the deceased alive on Sept. 5 , 19 58 , and that death occurred at 2:40 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED Sept. 5, 1958							
ACTUAL SIGNATURE C. S. Whitaker				M.D. _____			
PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.				Clarksville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 5, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		22d. LOCATION (City, town, or county) Ellicott City, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sona ADDRESS Catonsville, Md.				24a. REC'D BY REGISTRAR SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

10404

Reg. Dist. No.

10420

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5620 Southwick St.				e. STREET ADDRESS 5620 Southwick St.			
3. NAME OF DECEASED (Type or print) First IRA Middle S. Last SHANTZ				4. DATE OF DEATH Month Sept. Day 11, Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1879	9. AGE (In years last b. (11th day) yrs.) 78	IF UNDER 1 YEAR Months 11 Days 29	IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Printing		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Baden, Ontario, Canada		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Christian Shantz				14. MOTHER'S MAIDEN NAME Nancy Steiner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-05-4069		17. INFORMANT (Wife) Gladys B. Shantz		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerosis generalized DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 5 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1953 to Sept 11, 1958 , that I last saw the deceased alive on Sept. 11, 1958 , and that death occurred at 1.2 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4711 Highland Ave., Bethesda, Md. DATE SIGNED 9-12-58							
ACTUAL SIGNATURE Alfred S. Norton M.D.							
PHYSICIAN'S NAME (Type) ALFRED S. NORTON							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 16 58	
				24b. REGISTRAR'S SIGNATURE Wm. S. Travis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10421

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>50 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. STREET ADDRESS <u>13229 Medway Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Petta Marguerite Shaw</u>		4. DATE OF DEATH <u>Sept 9 1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi Gephart</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta</u> unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Geon Harris</u>		Address <u>3229 Medway Rd. Md.</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis (Repeated CVA's)</u> DUE TO (c) <u>Unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>9 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5 Sept</u> , 19 <u>58</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11602 Georgia Ave. Silver Spring Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Morris Perry</u> M.D.		PHYSICIAN'S NAME (Type) <u>Morris Perry</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page-4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

10406

10422

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 606 No. Horner's Lane	
3. NAME OF DECEASED (Type or print) First Henry Middle Francis Last Shelton		4. DATE OF DEATH Month September Day 21 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1911
9. AGE (In years last birthday) 46 yrs		IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min. 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Naval Medical Center	
11. BIRTHPLACE (State or foreign country) Rockville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Shelton		14. MOTHER'S MAIDEN NAME Maggie Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Lucinda Shelton	
17. INFORMANT Wife		Address As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis DUE TO (c) Hypertension w/ -b disease		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1-1/2 4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 1, 1958 to 9/21/58 , that I last saw the deceased alive on 9/21/58 , and that death occurred at 3:08 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones		ADDRESS (Street, city or town, state) Rockville, Md	
PHYSICIAN'S NAME (Type) Stephen N. Jones		DATE SIGNED 9/21/58	
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/24/58	22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE R.L. SNOWDEN ADDRESS Rockville, Md		24a. REC'D BY REGISTRAR SEP 24 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

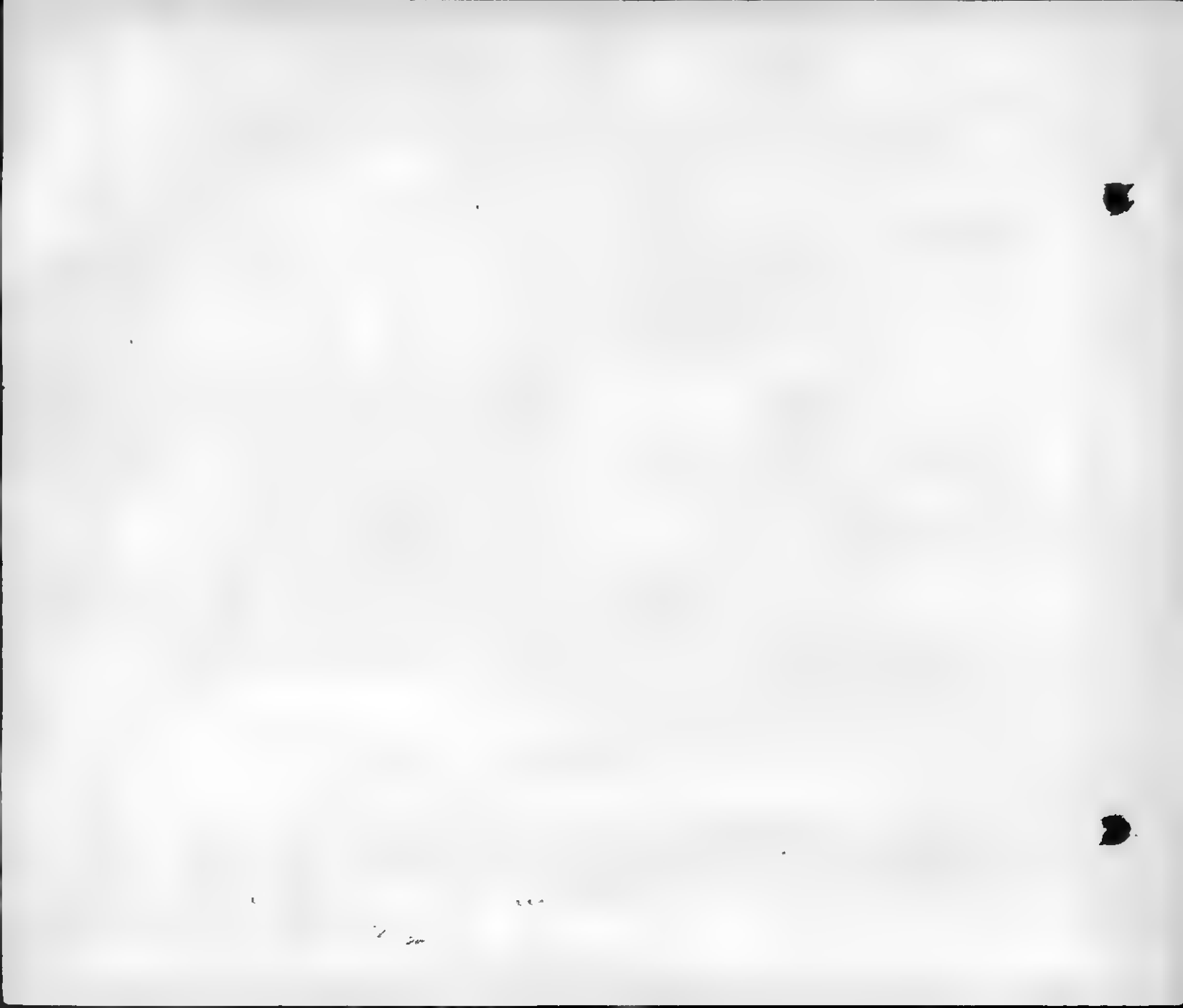
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10423

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) 9200 Old Georgetown Rd.		d STREET ADDRESS Dodge Hotel	
3. NAME OF DECEASED (Type or print) First Middle Last Lyle Gordon Shuck, Sr.		4. DATE OF DEATH Month Day Year Sept 13 1958	
5 SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1895
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min. 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt Print. Office		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	
11. BIRTHPLACE (State or foreign country) Grafton, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter Shuck		14. MOTHER'S MAIDEN NAME Minerva E. Sieff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs Ilda J. Shuck.		Address (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199.2 DUE TO Metastatic SARCOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) PRIMARY SITE Undetermined DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ONE YR?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947 to Sept 10, 1958 , that I last saw the deceased alive on Sept 7, 1958 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE DeWitt E. DeLawter M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 8025 ABERDEEN Rd 9/10/58	
PHYSICIAN'S NAME (Type) DeWitt E. DeLawter		Bethesda 14, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Cremation	Sept. 13, 1958	- Lees Crematorium	Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE John S. S. S.		ADDRESS 300 N. 1st St N.E.	
24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

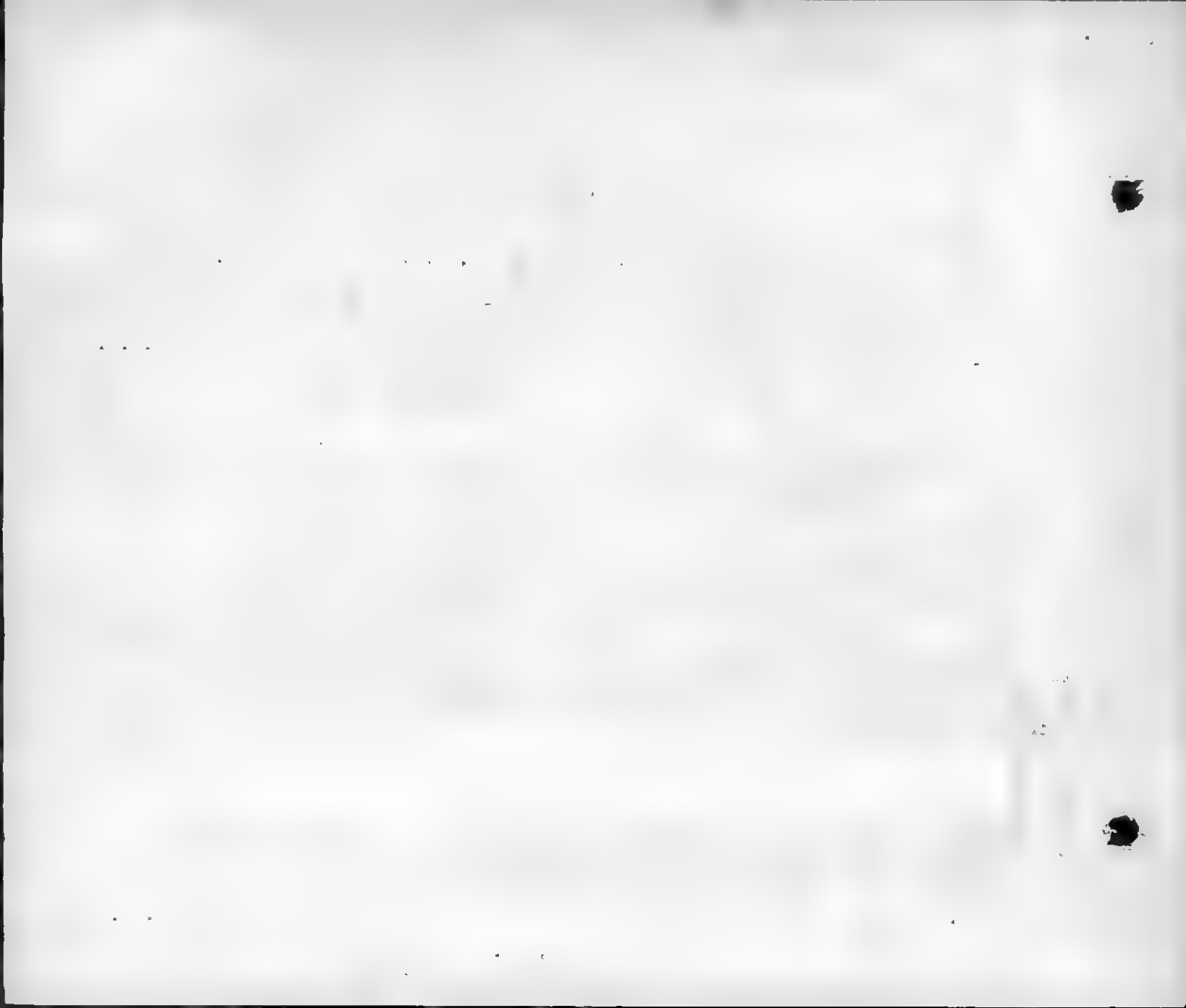


10408

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MO. TOWN: RY		2 USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE Maryland		b. COUNTY Mo. Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 703 Dale Drive		d. STREET ADDRESS 703 Dale Drive		e. IS RESID. F. ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise		Middle Wetherill		Last Slack, M.D.	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-30-1908		9. AGE (in years last birthday) 49 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		12. KIND OF BUSINESS OR INDUSTRY New Jersey		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME John B. Slack		15. MOTHER'S MAIDEN NAME Maud Wetherall		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW #2	
17. SOCIAL SECURITY NO. yes		18. INFORMANT John B. Slack, III - 703 Dale Drive		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate poisoning 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Found Dead on bedroom floor of home		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-8-58	
EXAMINER'S NAME (Type) FRANK J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION OR REMOVAL (Specify) Trans. & Burial		22b. DATE THEREOF 9/11/58		22c. NAME OF CEMETERY OR CREMATORY Woodlane Cemetery	
22d. LOCATION (City, town, or county) Burlington County, N. J.		22e. (State) N. J.			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE SEP 10 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10425

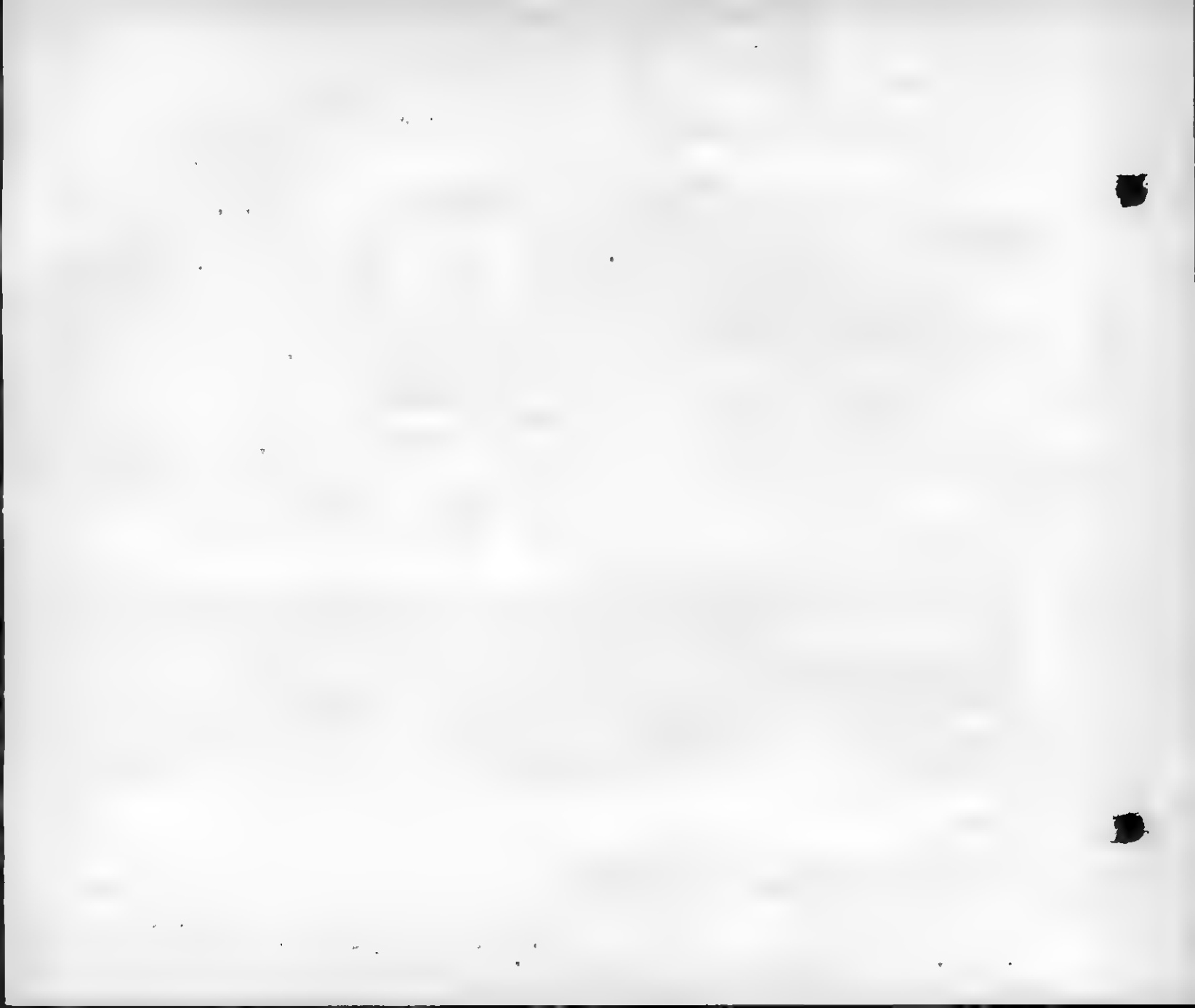
CERTIFICATE OF DEATH

10409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharon Nursing Home		d. STREET ADDRESS XXXXXXXXXXXXXXXXXXXX	
3. NAME OF DECEASED (Type or print) JOHANNA First Middle Last		4. DATE OF DEATH Sept. 22 1958 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Home Records - Olney, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion - Myocardial 420.1 DUE TO (b) Infarct - Far Advanced Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Cardiovascular PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days 20 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 21 Sept 1958 and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John B. Ziegler M.D. OLNEY, MD 22 Sept 58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) JOHN B. ZIEGLER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/58	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.		24a. REC'D BY REGISTRAR SEP 24 '58	
24b. REGISTRAR'S SIGNATURE Charles E. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10426

CERTIFICATE OF DEATH

Reg. Dist. No. 10410

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville, MD.</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1317 Center St.,</u>				d. STREET ADDRESS <u>1317 Center St.,</u>			
3. NAME OF DECEASED (Type or print) First <u>ELITE</u> Middle <u>JOHNA</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1875</u>	9. AGE (In years last birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		10. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>Eben Smith Wright</u>				14. MOTHER'S MAIDEN NAME <u>Kathryn Hulbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>---</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Miss Mildred Kathryn Smith, 1317 Center St., Beltsville, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Thromboses, multiple</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general, severe</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>12 yrs +</u> <u>12 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>---</u> Day <u>---</u> Year <u>19</u> Hour a. m. <u>---</u> p. m. <u>---</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>				20g. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>			
21. I certify that I attended the deceased from <u>1946</u> to <u>Sept 14, 1958</u> , that I last saw the deceased alive on <u>Sept 12, 1958</u> , and that death occurred at <u>---</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D. <u>3921 Tugomaire St.</u> DATE SIGNED <u>9.14.58</u>				PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> <u>Wash 15 DC</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>		22d. LOCATION (City, town, or county) <u>Tray</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chae Funeral Home,</u> ADDRESS <u>5143 Kirkman Ave., Wash. DC</u>				24a. REGD BY REGISTRAR <u>---</u> DATE <u>SEP 16 58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 10411

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 2 da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Overton Middle Jeter Last Smith				4. DATE OF DEATH Month 9 Day 23 Year 1958			
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-88	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR: Months 6 Days 9 Hours 15 Min.		11. IF UNDER 24 HRS: Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street oper.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? h. Amer.				13. FATHER'S NAME Kirby Smith			
14. MOTHER'S MAIDEN NAME Battie William				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO 578-10-7585				17. INFORMANT Hospital records. Address 7600 Carroll Ave T.P. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO BRONCHIOGENIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) WITH METASTASES DUE TO (c) WIT H NOT ASTHMA						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIO SCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7/11 19 58 to 9/23 19 58 , that I last saw the deceased alive on 9/22 19 58 , and that death occurred at 4:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE David Steiner				ADDRESS (Street, city or town, state) 1352 University Lane, Hyattsville			
PHYSICIAN'S NAME (Type) Francis Gasch's Sons				DATE SEP 25 '58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/58		22c. NAME OF CEMETERY OR CREMATORY Antioch Church		22d. LOCATION (City, town, or county) (State) XX Guinea Mills Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS 4739 Balto. Ave. Hyattsville, Md.		24. REC'D BY REGISTRAR Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10294

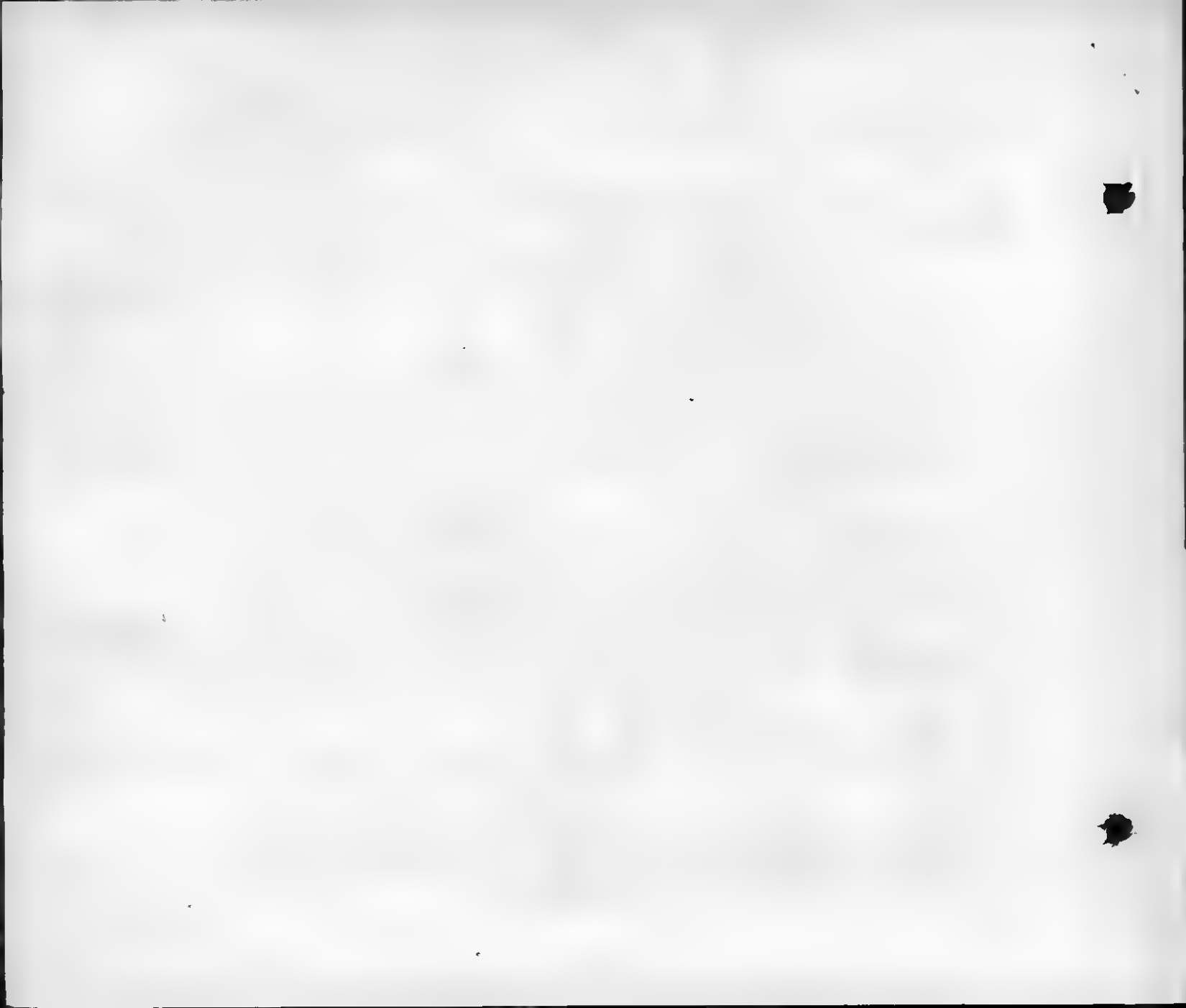
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. STREET ADDRESS <u>1527 Louden ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>ETTA</u> Middle <u>Heller</u> Last <u>STAMM</u>				4. DATE OF DEATH Month <u>9</u> Day <u>-22</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-80</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>77</u> Days <u>22</u> Hours <u>1958</u>		IF UNDER 24 HRS. Months <u>77</u> Days <u>22</u> Hours <u>1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13. FATHER'S NAME <u>Louis KOTZ</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Heller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Patent myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-21</u> , 19 <u>58</u> , to <u>9-22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-22</u> , 19 <u>58</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>427 PERSHING DR. SILVER SPRING MD</u> DATE SIGNED <u>9-22-58</u>							
ACTUAL SIGNATURE <u>Abraham W. Danish</u>				M.D. <u>SILVER SPRING MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal & cremation</u>		<u>9/22/58</u>		<u>Chelton Hills Crematory</u>		<u>Philadelphia, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Juska</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10427

CERTIFICATE OF DEATH

Reg. Dist. No.

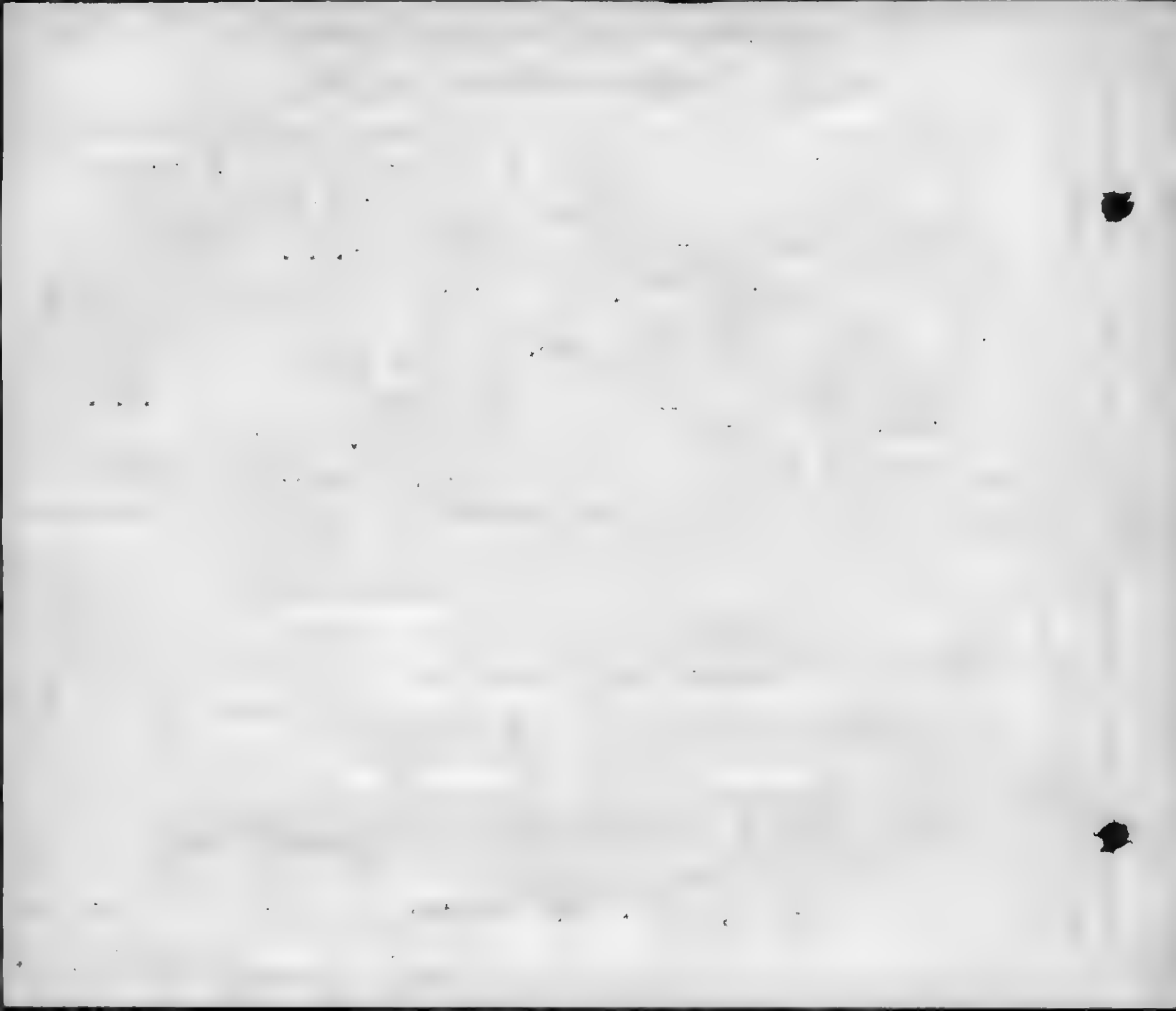
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		STATE Maryland COUNTY Montgomery		CITY (If outside corporate limits, write RURAL OR and give nearest town) Gaithersburg		LENGTH OF STAY (In this place) 3 Years	
CITY OR TOWN Germantown		CITY OR TOWN Gaithersburg		STREET ADDRESS M.F.D. I		HOSPITAL OR INSTITUTION OR STREET ADDRESS The Marylander Home	
3. NAME OF DECEASED (Type or Print) (First) Katherine (Middle) C. (Last) Sutliff				4. DATE OF DEATH (Month) Sept (Day) 5 (Year) 1958			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Dec. 23 1878	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael E Carley				14. MOTHER'S MAIDEN NAME Marie C. Fleming			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, or, unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Vinoent Sutliff		18. Same As 2	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) ACUTE CONGESTIVE HEART FAILURE				INTERVAL BETWEEN ONSET AND DEATH 24 HRS.			
ANTECEDENT CAUSE(S) DUE TO (B) ARTERIO-SCLEROTIC HEART DISEASE				20 YRS.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) ESSENTIAL HYPERTENSION				25 YRS.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. MULTIPLE MYOCARDIAL-VASCULAR ACCIDENTS				4 YRS.			
DIVERTICULITIS, CHRONIC				8 YRS.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from SEPT. 5, 1958 , to SEPT. 5, 1958 , that I last saw the deceased alive on SEPT. 5, 1958 , and that death occurred at 8:50 A.M. from the causes and on the date stated above.							
SIGNATURE Reamur S. Donnelly M.D. 1827 23RD ST. N.W. WASH DC 9/5/58				DATE SIGNED 9/5/58			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept 8, 58		NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		LOCATION (City, town, or county) (State) Flushing New York	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Arthur S. Kline		25. FUNERAL DIRECTOR'S SIGNATURE Ray A. Barber		ADDRESS Laytonville, Md.	
DATE SEP 8 '58							

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

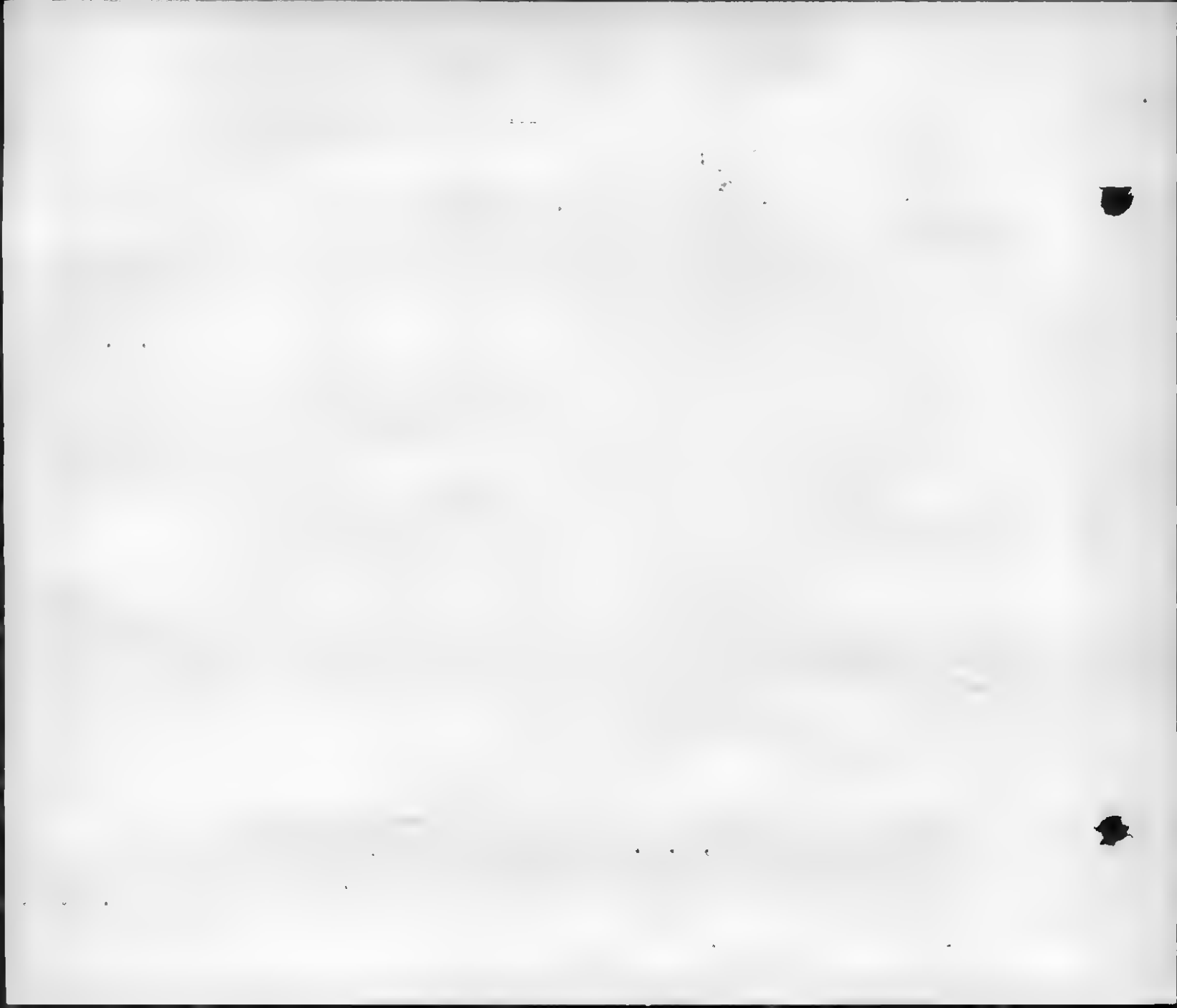
10428

CERTIFICATE OF DEATH

10414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 7647 Greenleaf Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Phillip Sutphin		4. DATE OF DEATH Month Day Year September 14, 1958					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1893	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Sutphin			14. MOTHER'S MAIDEN NAME Molly Sutphin				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Staphylococcal Septicemia</i> DUE TO <i>Staphylococcal Bacteraemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Acute Leukemia</i> DUE TO (c) <i>Acute Leukemia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Leukemia</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3-4 days</i> <i>" "</i> <i>approx 8 mos</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 19, 1958, to September 14, 1958, that I last saw the deceased alive on September 14, 1958, and that death occurred at 3:30 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>The Clinical Center</i> DATE SIGNED <i>9/15/58</i>							
ACTUAL SIGNATURE <i>Leonard Garren</i> M.D.			The Clinical Center The National Institutes of Health Bethesda 14, Maryland				
PHYSICIAN'S NAME (Type) <i>Leonard Garren, M. D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE SEP 22 38		24b. REGISTRAR'S SIGNATURE <i>W. W. Chambers</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

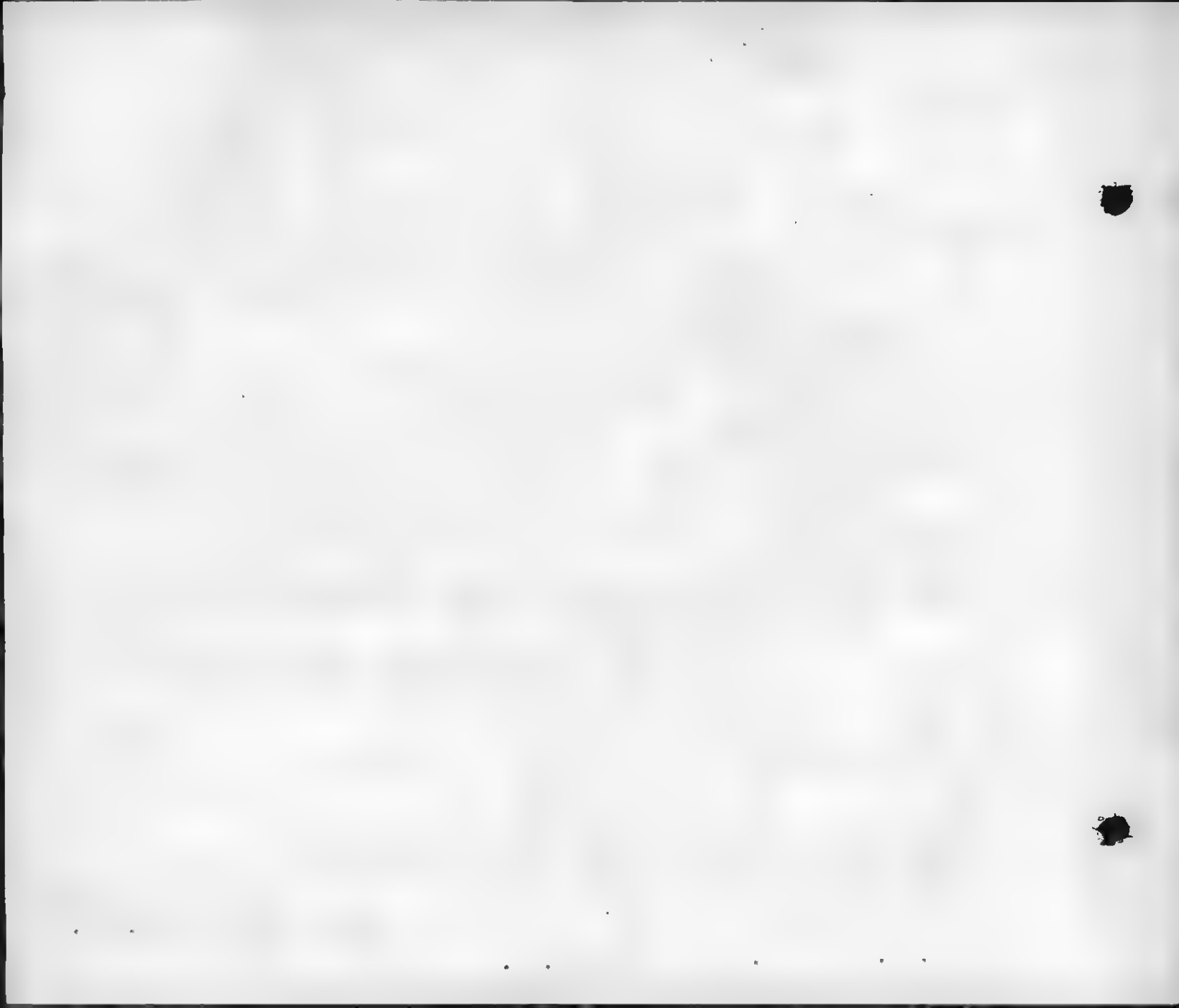
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10425 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10415

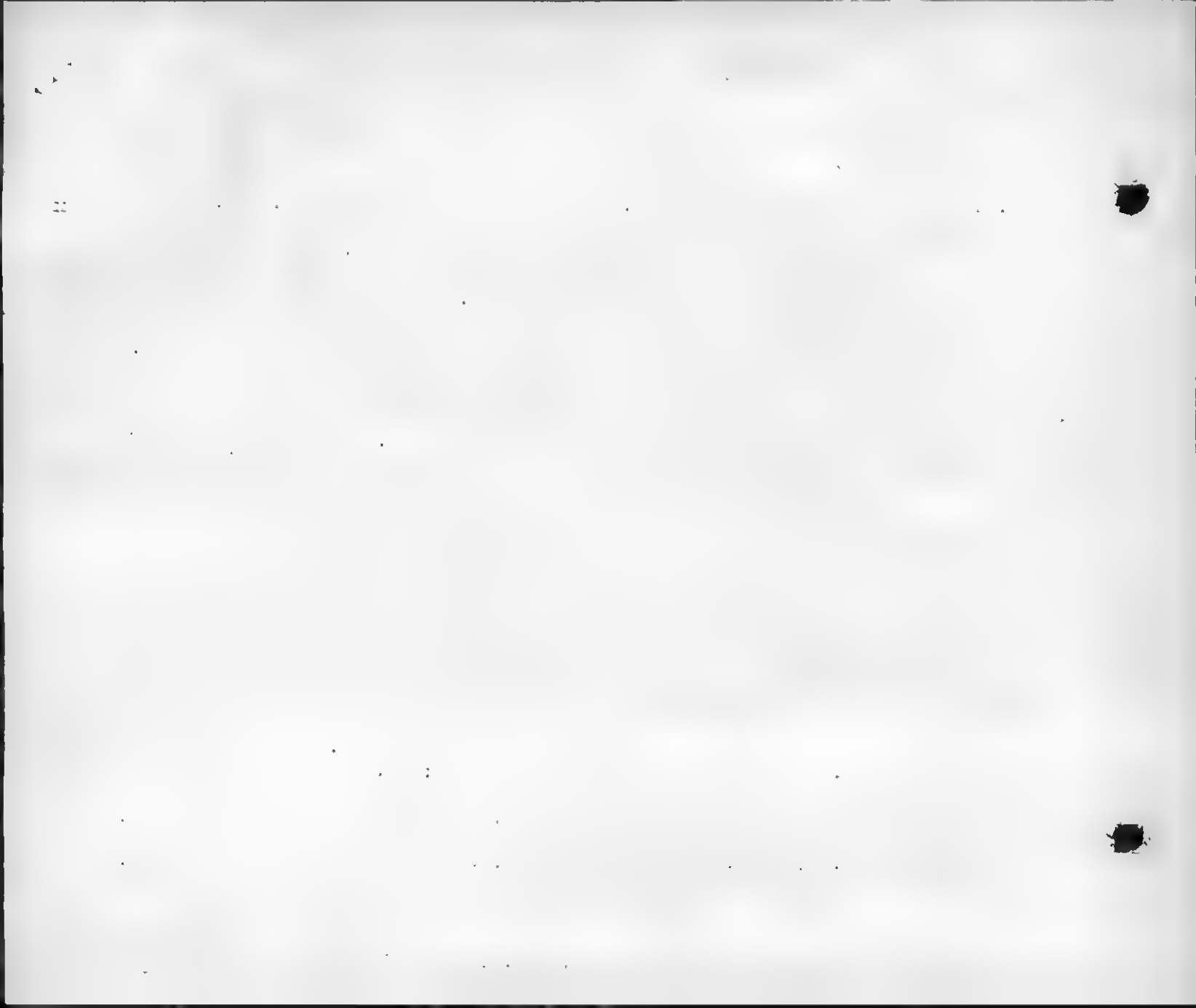
Reg. Dist. No.

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <u>md</u> b COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7802 Tomlinson Ave</u>		d. STREET ADDRESS <u>7802 Tomlinson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Alonzo Morgan Thomas Jr</u>		4. DATE OF DEATH <u>Sept 1 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-1913</u>
9. AGE (in years last birthday) <u>45</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>1</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Card Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. GOVT.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alonzo M. Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Selma Wenzel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW2</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Selma Thomas (Mother)</u>		Address <u>Stn 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>19</u> Day <u>1</u> Year <u>1958</u> Hour <u>4:20</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9-1-58</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>SEP 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10416
Item 3, Film G-234 9/26/58.cac.										
10430										
CERTIFICATE OF DEATH										
Reg. Dist. No. 215										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o STATE District of Columbia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.					d. STREET ADDRESS 1524 Potomac Ave., S.E.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) Elise Elsie "S" THOMPSON					4. DATE OF DEATH Month September Day 14 Year 19 58					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Sept. 1884		9. AGE (In years last birthday) 74 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Soren ANDERSEN					14. MOTHER'S MAIDEN NAME Ellen ANDERSEN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Axel K. THOMPSON (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, Left Breast with Metastases										
DUE TO (b) _____										
DUE TO (c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										
INTERVAL BETWEEN ONSET AND DEATH Undetermined										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____										
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work										
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										
20f. (City or town) _____ (County) _____ (State) _____										
21. I certify that I attended the deceased from 23 August , 19 58 , to 14 Sept. , 19 58 , that I last saw the deceased alive on 14 Sept. , 19 58 , and that death occurred at 11:00 P. M., from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-15-58										
ACTUAL SIGNATURE Burt C. Johnson M.D.										
PHYSICIAN'S NAME (Type) Burt C. Johnson, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										
22b. DATE THEREOF 9-18-58										
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery										
22d. LOCATION (City, town, or county) Suitland, Maryland (State) _____										
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th & Mass Ave., N.W. Wash.D.C. ADDRESS _____										
24a. REC'D BY REGISTRAR SEP 19 '58 DATE _____										
24b. REGISTRAR'S SIGNATURE Arthur S. Hana										



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10417

10431

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>District of Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47V 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomena's Rest Home</u>				d. STREET ADDRESS <u>1604 Michigan Ave. N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>K.</u> Last <u>Towles</u>				4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/8. 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Ret. Inesstate Come Govern.</u>		11. BIRTHPLACE (State or foreign country) <u>Elkins N. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William L. Kee</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine Pharris</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Laurence E. Towles</u> Address <u>1604 Mich Ave Wash. D.C. NE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Chronic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>& atherosclerosis</u> (c) <u>3 months</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6 June 58</u> to <u>7 Sept 58</u> that I last saw the deceased alive on <u>31 Aug 58</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert C. Haile</u> M.D. <u>55 M. Ave. N.W. D.C.</u> <u>9/17/58</u>				PHYSICIAN'S NAME (Type) <u>ROBERT C. HAILE</u> <u>135-N.Y. Ave. N.W. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/10/58</u>		<u>St. Clair</u>		<u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Galley's Funeral Home</u> ADDRESS <u>mt. Rainier Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10418

10432

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9938 Mayfield Drive</u>		e. STREET ADDRESS <u>9938 Mayfield Drive</u>	
3. NAME OF DECEASED (Type or print) <u>BETTYE JO TREMMEL</u>		4. DATE OF DEATH <u>Sept. 23, 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1922</u>
9. AGE (In years last birthday) <u>36</u> yrs		10. IF UNDER 1 YEAR <u>1</u> Months <u>19</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph E. Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Ailley C. Sterrett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ernest D. Tremmel-husband-same as 2a</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> <u>777x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stab wound in left chest (Heart)</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>found dead on bedroom floor</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Reported to have been under psychiatric treatment</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Self inflicted wound in left chest</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> PM <u>9/23/1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bethesda, Maryland</u> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) <u>Silver Spring, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 25 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

10419

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			
c. LENGTH OF STAY IN 1b <u>2 weeks</u>				d. STREET ADDRESS <u>7107 Cedar Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7107 Cedar Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Judith ANN</u> Middle <u>Reanne</u> Last <u>VERE</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25, 1958</u>	
9. AGE (In years lost birthday) yrs <u>2</u>		10. IF UNDER 1 YEAR Months <u>23</u> Days <u>23</u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>			
13. FATHER'S NAME <u>JOHN W. VERE</u>				14. MOTHER'S MAIDEN NAME <u>GERTRUDE A. THOMPSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Mr. John W. Vere, 7107 Cedar Ave.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>774X</u> <u>Local interstitial pneumonitis, early</u> DUE TO (b) <u>Possible Septicemia (penicillin abscess)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Capillary hemangioma of skin and liver</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible Septicemia (penicillin abscess)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Birth</u> , 19 <u>58</u> , to <u>Sept 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 16</u> , 19 <u>58</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9927 Pershing Dr., Silver Spring, Md.</u> DATE SIGNED <u>Winston E. Cochran</u>							
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D.				DATE SIGNED <u>SEP 22 '58</u>			
PHYSICIAN'S NAME (Type) <u>WINSTON E. COCHRAN</u>				22a. REC'D BY REGISTRAR <u>Carlton S. Kline</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>9/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziaka</u>				24. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			
d. STREET ADDRESS 10519 Warfield St.				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First EARL Middle A Last WAGNER				4. DATE OF DEATH Month Sept Day 15 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/5/14	
9. AGE (In years, last birthday) 44 yrs.		IF UNDER 1 YEAR Months 6 Days 10		IF UNDER 24 HRS Hours 6 Min. 10			
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY Plumbing Cont		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME WA. WAGNER				14. MOTHER'S MAIDEN NAME LAVINIA DAYMUDR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. Yes-Unknown		17. INFORMANT Mother Address Mrs. William A Wagner-same as 2D	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE FROM ESOPHAGEAL VARICES						1 DAY	
1.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) PORTAL CIRRHOSIS	
						(c) YPMRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SQUAMOUS CELL CARCINOMA PHARYNX WITH METASTASES							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from 1950 to Sept 15, 1958 , that I last saw the deceased alive on Sept 14, 1958 , and that death occurred at 6:03 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 8025 ABERDEEN RD DATE SIGNED 9/15/58							
ACTUAL SIGNATURE DeWitt E. Delawter M.D.							
PHYSICIAN'S NAME (Type) DeWitt E. DELAWTER				Bethesda 14, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE C. L. & T. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5004 DelRay Avenue</u>		e. STREET ADDRESS <u>5004 DelRay Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>M. A.</u> Last <u>WAHL</u>		4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>? Kroeger</u>		14. MOTHER'S MAIDEN NAME <u>? Filter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>John A. Wahl - son - 4826 McArthur Blvd. N.W.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> <u>4-20-0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>congestive heart failure</u> (c) <u>arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u> <u>3 mos.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1949</u> to <u>13 Sept. 1958</u> , that I last saw the deceased alive on <u>13 Sept. 1958</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7659 Old Georgetown Rd. Beth 9/13/58</u>			
ACTUAL SIGNATURE <u>John M. Wyman</u>		M.D. <u>7659 Old Georgetown Rd. Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John M. Wyman</u>		<u>7659 Old Georgetown Rd. Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/16/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Krand</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 2-24-58 et
10435
CERTIFICATE OF DEATH

10422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONT GOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>155 Hutton Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Ward</u>				4. DATE OF DEATH Month Day Year <u>9-24-58</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-74</u>	9. AGE (In years last birthday) <u>34</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>INDIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL PIAN</u>				14. MOTHER'S MAIDEN NAME <u>MARY C'CONNELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Marion Ward 5030 1st St. N.W. Wash D.C.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure.</u> <u>331X</u> DUE TO <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension, Arteriosclerosis.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 12, 1958</u> , to <u>9/24, 1958</u> , that I last saw the deceased alive on <u>Sept 21, 1958</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Luciano L. Leal</u> M.D.				ADDRESS (Street, city or town, state) <u>108 N. Frederick Ave.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Luciano L. Leal</u>				<u>Gaithersburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Melrose, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821 14th. St. N.W. Wash. D. C.</u>				24a. REC'D BY REGISTRAR <u>SEP 26 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



10436

CERTIFICATE OF DEATH

Reg. Dist. No.

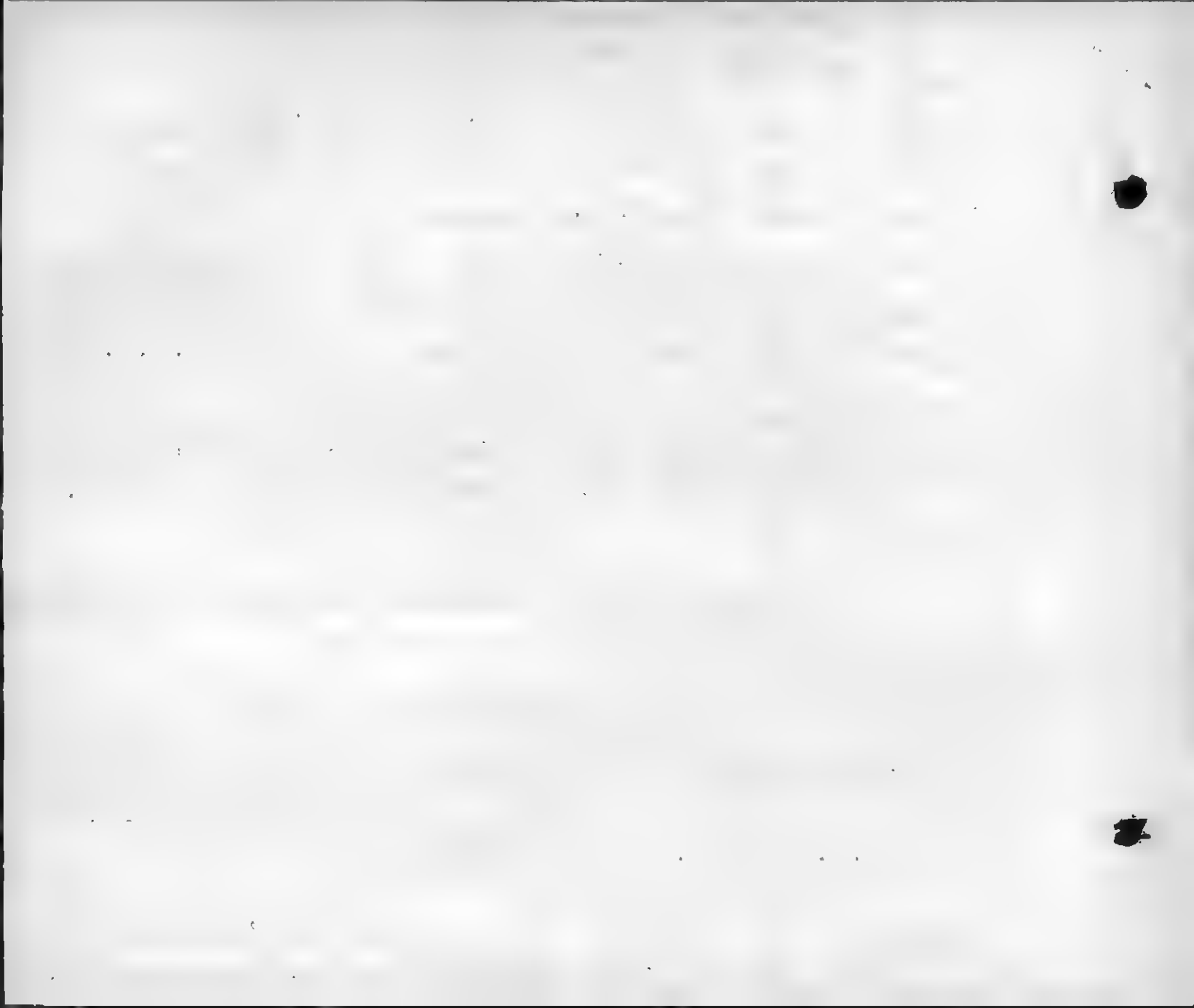
1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 21 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia b. COUNTY Loudon c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bluemont d. STREET ADDRESS RD #1, Box 85 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Thomas Shamrock Warner				4. DATE OF DEATH Month Day Year September 23, 1958			
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 8, 1880	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Masonry		11 BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Warren			14. MOTHER'S MAIDEN NAME Katherine Jordan				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of Prostrate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last, (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 2, 1958 to September 23, 1958 , that I last saw the deceased alive on September 23, 1958 , and that death occurred at 6:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. R. Rose (RGS)		M.D. The Clinical Center		ADDRESS (Street, city or town, state) 9-23-58			
PHYSICIAN'S NAME (Type) J. R. Rose, M. D.		The National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/58		22c. NAME OF CEMETERY OR CREMATORY Negro Cemetery		22d. LOCATION (City, town, or county) (State) Middleburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Rose			ADDRESS 7552 Wisconsin Ave Bethesda		24a. REC'D BY REGISTRAR SEP 25 58		
					24b. REGISTRAR'S SIGNATURE Arthur S. Henshaw		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION



1 10438 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

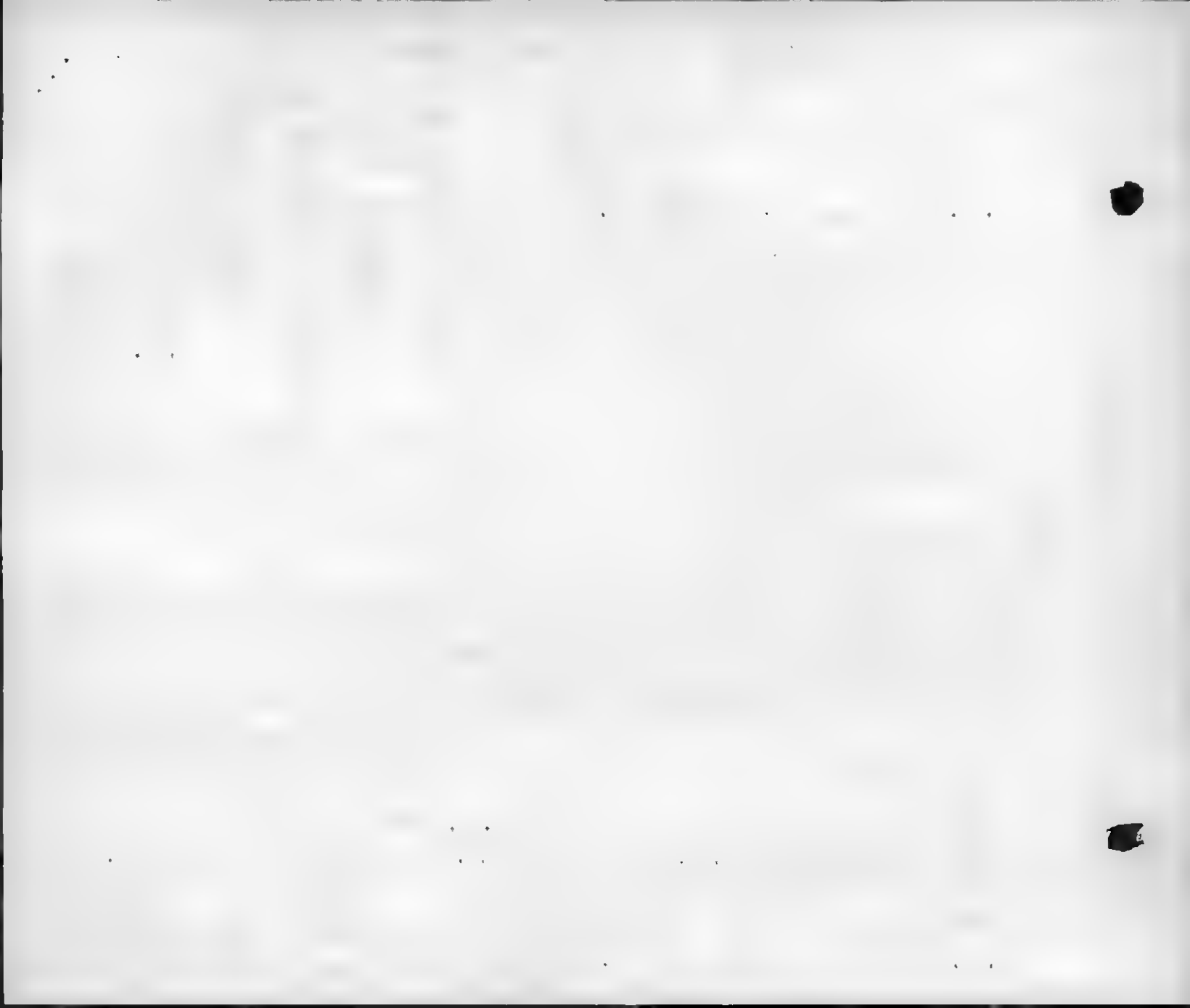
CERTIFICATE OF DEATH

10425
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	
f. STREET ADDRESS Schniders Traylor Court		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anthony Middle Faron Last WHITE		4. DATE OF DEATH Month September Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 September 1958
9. AGE (In years last birthday) yrs 15 Months 15 Days 15 Hours 15 Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Lee Olin WHITE		14. MOTHER'S MAIDEN NAME Ida Ann DUVALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Lee Olin WHITE (Same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bacteremia, Staphylococcus aureus DUE TO (b) Prematurity DUE TO (c) None		INTERVAL BETWEEN ONSET AND DEATH 12 days 15 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 September, 19 58 , to 17 September, 19 58 , that I last saw the deceased alive on 17 September, 19 58 , and that death occurred at 1:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE David Harris		ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, Bethesda, Md 9-17-58	
PHYSICIAN'S NAME (Type) David Harris, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 9-19-58	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		22d. LOCATION (City, town, or county) (State) Gaithersburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24a. REC'D BY REGISTRAR SEP 19 58	
24b. REGISTRAR'S SIGNATURE Orlando S. Pumphrey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

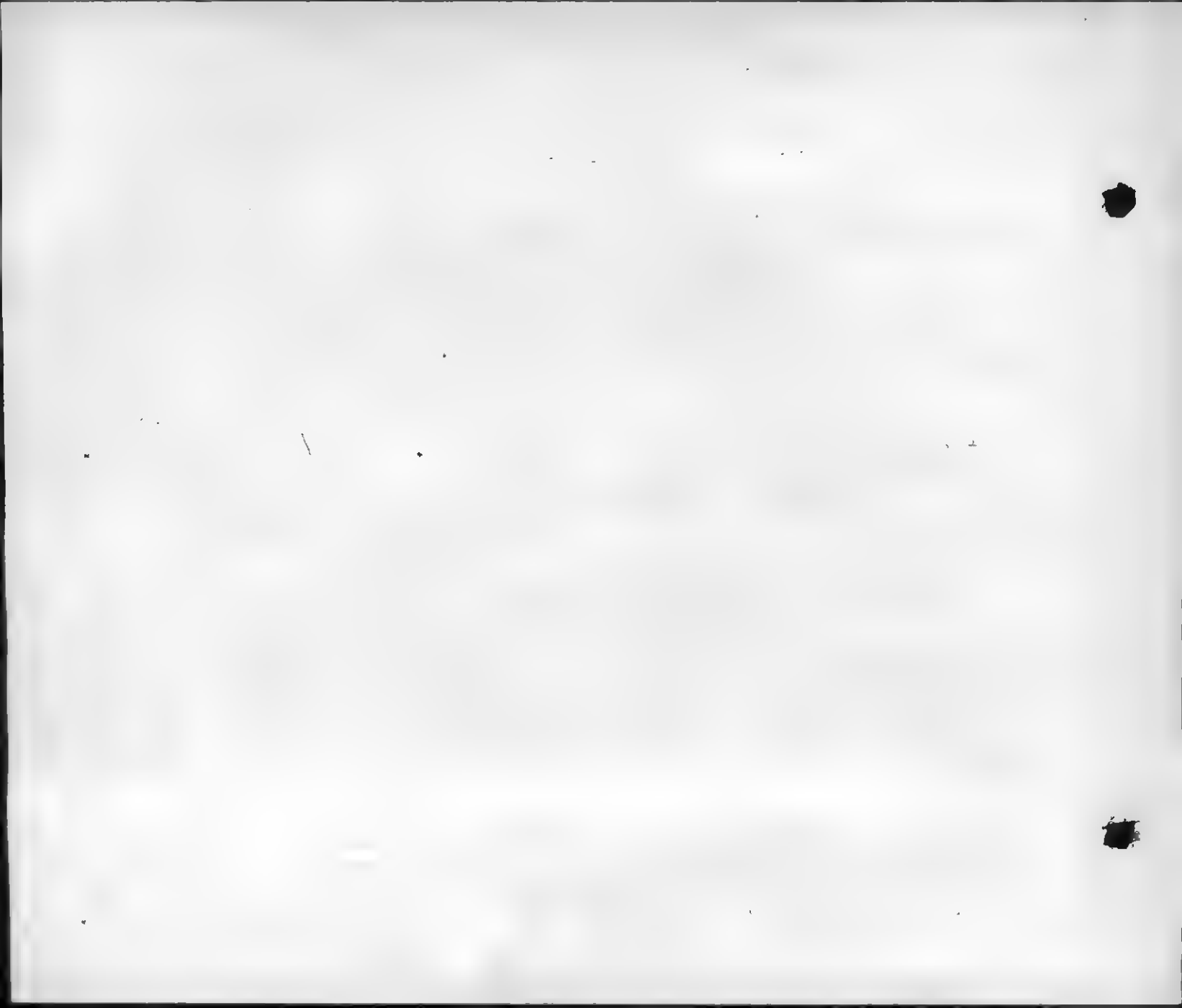
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1043 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 10 Year	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6816 Brookville Rd.		d. STREET ADDRESS 6816 Brookville Rd.	
3. NAME OF DECEASED (Type or print) Harry Franklin White		4. DATE OF DEATH Month Sept. Day 15 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/24/1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Gov. employee	9. AGE (In years last birthday) 83 yrs.
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin White		14. MOTHER'S MAIDEN NAME Martha Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO None	
17. INFORMANT Bernard H. White, / Radnor, Penn.		Address 582 Cricket	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 9/15/58	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 17	
22c. NAME OF CEMETERY OR CREMATORY Laytonsville		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber		24a. REC'D BY REGISTRAR SEP 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death



MD 10-10-58
10296
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Filed 10/10/58 cec.

CERTIFICATE OF DEATH

10427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Rachel White		4. DATE OF DEATH Sept 10 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Charles G. Harman		14. MOTHER'S MAIDEN NAME Mary F. Fluery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 Congestive HEART Failure DUE TO (b) Pneumonia, Left & Right Lung DUE TO (c) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 28 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, Pernicious type. Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 49	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1958 to Sept 10, 1958 , that I last saw the deceased alive on Sept 10, 1958 , and that death occurred at 8:05 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE George B. Patrick, Jr. M.D.		ADDRESS (Street, city or town, state) 8700 Colesville Rd. DATE SIGNED 9-10-58	
PHYSICIAN'S NAME (Type) George B. Patrick, Jr. M.D.		Silver Spring, Md.	
22a. BURIAL, CREMATION, or REMOVAL (Specify) 9-13-1958		22b. NAME OF CEMETERY OR CREMATORY Congressional Cem.	
22c. LOCATION (City, town, or county) (State) Washington, D.C.		23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus ADDRESS 4411 Mac Br. Washington, D.C.	
24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10440

CERTIFICATE OF DEATH

Reg. Dist. No. 10428

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 mins</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>9807 RIVER Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fredrick</u> Middle <u>Whitmore</u> Last <u>Whitmore</u>				4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 17, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>4</u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Express Del. Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Express Co</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Joseph Whitmore</u>				14. MOTHER'S MAIDEN NAME <u>Mary Carr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Niece Mrs Ruth Leach Alexandria, Va</u>		Address <u>211 E. Deford</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Corporation, Metastatic carcinoma to Colon</u> DUE TO (c) <u>Carcinoma of Stomach</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 29, 1958</u> , 19 <u>58</u> , to <u>Oct 14, 1958</u> , that I last saw the deceased alive on <u>Sept 29, 1958</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bethesda 14 Maryland</u> DATE SIGNED <u>9-26-58</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Bethesda 14 Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept 29, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Proctor Park</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ziskel Funeral Home</u>				ADDRESS <u>510 E. St</u>		24a. REC'D BY REGISTRAR <u>SEP 30 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>William J. Gable</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10441

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF DECEASED (Type or print) First <u>Newborn Infant</u> Middle <u>Girl</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>2 hrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer M. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Maddox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Elmer M. Williams</u>		Address <u>2915 Woodstock Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>760.0</u> DUE TO <u>irregular hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anoxia</u> (c) _____ DUE TO _____ DUE TO _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>9/11</u> , 19 <u>58</u> , to <u>9/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/11</u> , 19 <u>58</u> , and that death occurred at <u>9:50 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>9/12/58</u>			
ACTUAL SIGNATURE <u>William J. Evans</u> M.D.		PHYSICIAN'S NAME (Type) <u>WILLIAM J. EVANS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>	22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR <u>SEP 15 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Charles E. K... ..</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10442

CERTIFICATE OF DEATH

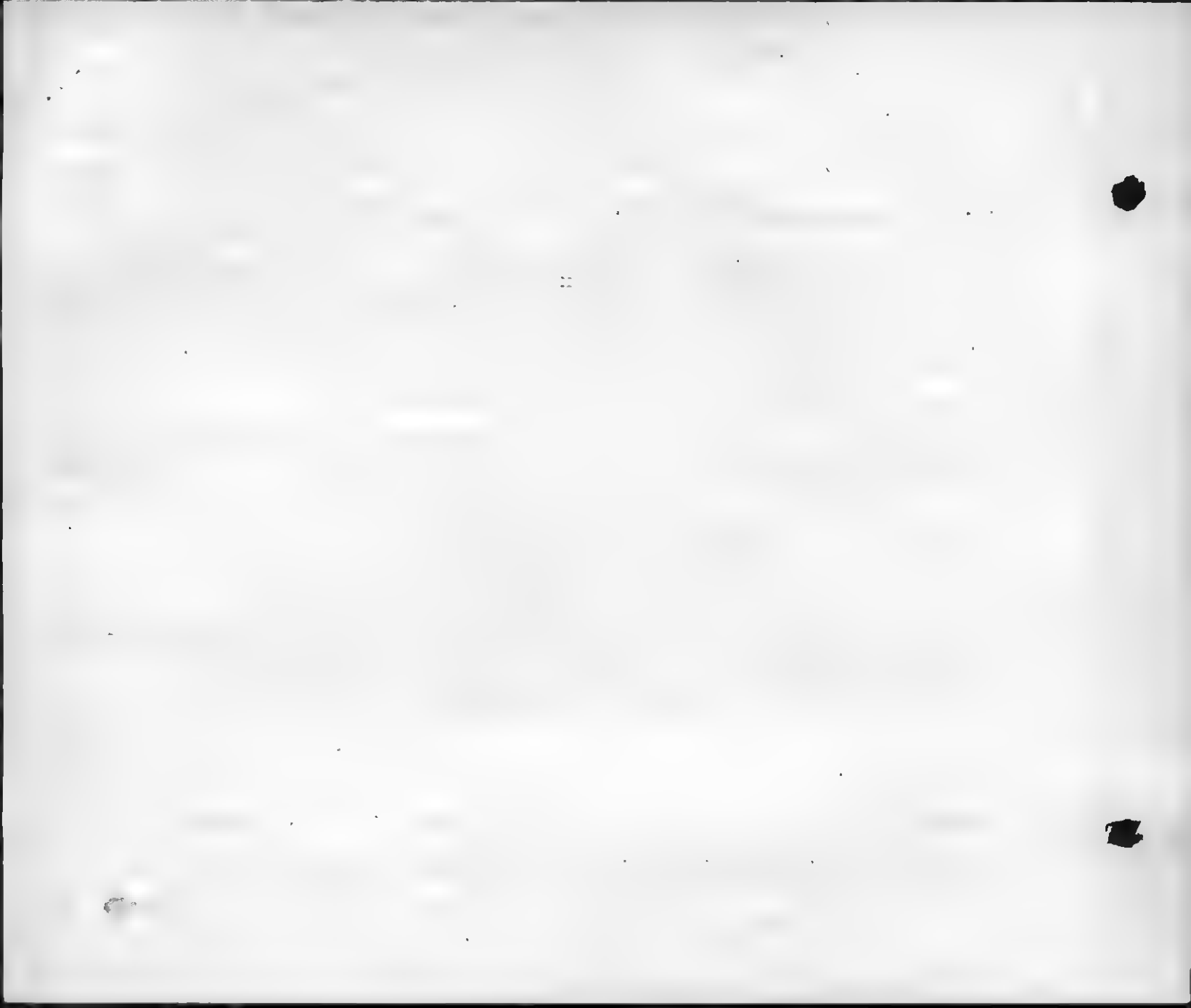
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 6622 Willston Place	
3. NAME OF DECEASED (Type or print) First Thomas Middle Jeffrey Last WINSTEAD		4. DATE OF DEATH Month September Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Sept. 1958
9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR: Months 6 Days 6 Hours 6 Min 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Finley Gilbert WINSTEAD		14. MOTHER'S MAIDEN NAME Joan Marie KLEIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Finley G. Winstead (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) meningitis 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) meningoencephal DUE TO (c) spina bifida		INTERVAL BETWEEN ONSET AND DEATH 1 day 6 " 6 "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Sept. 19 58 to 7 Sept. 19 58 , that I last saw the deceased alive on 7 Sept. 19 58 and that death occurred at 4:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-8-58			
ACTUAL Howard A. Pearson M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Walter N. Morris Arlington Funeral Home 3901 N. Fairfax Dr.		24a. REC'D BY REGISTRAR SEP 9 '58	
24b. REGISTRAR'S SIGNATURE Cecil S. Knease			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051254XV6



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10443 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10431

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 30 hrs. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>7703 Westfield Dr.</u>	
3. NAME OF <u>Townley R Wolfe IV</u> (Type or print) First Middle Last		4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-'44</u>
9. AGE (In years last birthday) <u>14</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Townley R. Wolfe III</u>		14. MOTHER'S MAIDEN NAME <u>Doris Knoche</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Father</u>		Address <u>Townley R Wolfe III</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE INTRACEREBRAL HEMORRHAGES</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MULTIPLE CEREBRAL CONTUSIONS AND LACERATIONS</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>31 hours</u> <u>31 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Riding bicycle & struck by auto</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9:24</u> a.m. <u>9/23</u> 19 <u>58</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	20f. (City or town) <u>Bethesda</u> (County) <u>montg</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/29/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>		24a. REC'D BY REGISTRAR <u>SEP 30 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			
Ellsworth Armacost-4600 Liberty Hgts. Ave.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

10432
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6809 Delaware St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Chevy Chase d. STREET ADDRESS 6809 Delaware Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BARBARA First HILMAN Middle WURDEMAN Last 4. DATE OF DEATH Sept. 1 1958 Month 1 Day 19 Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11/19/70 9. AGE (in years last birthday) 87 yrs. If UNDER 1 YEAR: Months 5 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Daniel Artes 14. MOTHER'S MAIDEN NAME Sophia Keremlin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT Mrs Karl Plitt-Item # 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial decomp 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocardial decomp. (c) Arteriosclerosis, general, severe		INTERVAL BETWEEN ONSET AND DEATH 15 min. 6 months 4 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma, chronic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from March 1957 to Sept 1 1958 , that I last saw the deceased alive on Aug 15 1958 , and that death occurred at 8:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St. Wash 15 D.C. DATE SIGNED 9-1-58 ACTUAL SIGNATURE Stewart Clapp M.D. PHYSICIAN'S NAME (Type) Stewart Clapp Wash 15 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/3/58 22c. NAME OF CEMETERY OR CREMATORY Prospect Hill 22d. LOCATION (City, town, or county) (State) Washington, D.C.		23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. ADDRESS 24a. REC'D BY REGISTRAR SEP 2 58 DATE 24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

Coroner Notified and released case

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be reformed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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THE UNIVERSITY OF CHICAGO
 PRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10445

CERTIFICATE OF DEATH

10433

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William H. Young</u>				4. DATE OF DEATH Month Day Year <u>Sept. 6 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/15/83</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salem, Mass.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas Young</u>				14. MOTHER'S MAIDEN NAME <u>Martha Monroe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-34-6325</u>		17. INFORMANT Address <u>Anna Young - Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rt. Hemiplegia, severe, with aphasia</u> DUE TO <u>334x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general, severe</u> DUE TO <u>5 yrs +</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiplegia, severe</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>Sept 6, 1958</u> , that I last saw the deceased alive on <u>Sept 5, 1958</u> , and that death occurred at <u>7:20 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W. Wash 15 D.C.</u> DATE SIGNED <u>9.6.58</u>							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				M.D. <u>3921 Ingomar St. N.W. Wash 15 D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haud</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-10

<p>1. Name of deceased (Print name in full)</p>	
<p>2. Sex (M or F)</p>	
<p>3. Date of birth (Month, day, year)</p>	
<p>4. Place of birth (City, town, village, or country)</p>	
<p>5. Usual residence (Street, city, town, village, or country)</p>	
<p>6. Date of death (Month, day, year)</p>	
<p>7. Place of death (City, town, village, or country)</p>	
<p>8. Cause of death (Specify disease, injury, or poison)</p>	
<p>9. Signature of attending physician (Print name and sign)</p>	
<p>10. Signature of registrar (Print name and sign)</p>	
<p>11. Signature of informant (Print name and sign)</p>	
<p>12. Signature of witness (Print name and sign)</p>	
<p>13. Signature of coroner (Print name and sign)</p>	
<p>14. Signature of medical examiner (Print name and sign)</p>	
<p>15. Signature of health officer (Print name and sign)</p>	
<p>16. Signature of registrar (Print name and sign)</p>	
<p>17. Signature of informant (Print name and sign)</p>	
<p>18. Signature of witness (Print name and sign)</p>	
<p>19. Signature of coroner (Print name and sign)</p>	
<p>20. Signature of medical examiner (Print name and sign)</p>	
<p>21. Signature of health officer (Print name and sign)</p>	
<p>22. Signature of registrar (Print name and sign)</p>	
<p>23. Signature of informant (Print name and sign)</p>	
<p>24. Signature of witness (Print name and sign)</p>	
<p>25. Signature of coroner (Print name and sign)</p>	
<p>26. Signature of medical examiner (Print name and sign)</p>	
<p>27. Signature of health officer (Print name and sign)</p>	
<p>28. Signature of registrar (Print name and sign)</p>	
<p>29. Signature of informant (Print name and sign)</p>	
<p>30. Signature of witness (Print name and sign)</p>	
<p>31. Signature of coroner (Print name and sign)</p>	
<p>32. Signature of medical examiner (Print name and sign)</p>	
<p>33. Signature of health officer (Print name and sign)</p>	
<p>34. Signature of registrar (Print name and sign)</p>	
<p>35. Signature of informant (Print name and sign)</p>	
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<p>45. Signature of health officer (Print name and sign)</p>	
<p>46. Signature of registrar (Print name and sign)</p>	
<p>47. Signature of informant (Print name and sign)</p>	
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<p>49. Signature of coroner (Print name and sign)</p>	
<p>50. Signature of medical examiner (Print name and sign)</p>	
<p>51. Signature of health officer (Print name and sign)</p>	
<p>52. Signature of registrar (Print name and sign)</p>	
<p>53. Signature of informant (Print name and sign)</p>	
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<p>55. Signature of coroner (Print name and sign)</p>	
<p>56. Signature of medical examiner (Print name and sign)</p>	
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<p>62. Signature of medical examiner (Print name and sign)</p>	
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<p>99. Signature of health officer (Print name and sign)</p>	
<p>100. Signature of registrar (Print name and sign)</p>	